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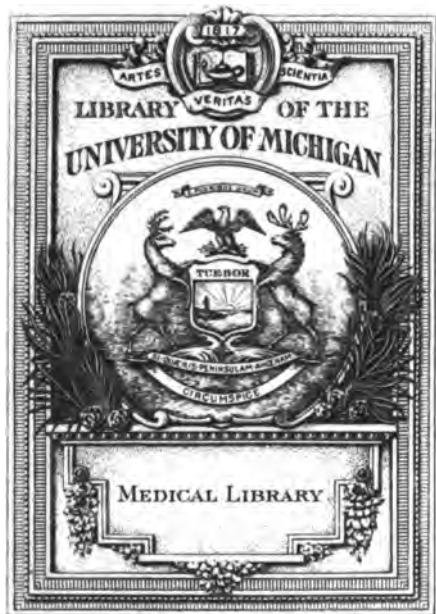
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Henry P. Lyman

American psychiatric Association.





Wm. L. Gorman

American psychiatric association.

PROCEEDINGS

OF THE

American Medico-Psychological Association

AT THE

SEVENTY-SIXTH ANNUAL MEETING

HELD AT

CLEVELAND, OHIO, June 1-4, 1920



PUBLISHED BY

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1920

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American Medico-Psychological Association
FOR 1919-1920

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AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.

PROCEEDINGS OF THE SEVENTY-SIXTH ANNUAL MEETING.

CLEVELAND, OHIO, TUESDAY, JUNE 1, 1920.

FIRST SESSION.

The Association convened at 10 a. m. in the convention hall of the Hotel Statler, Cleveland, Ohio, and was called to order by the President, Dr. Henry C. Eyman, Massillon, Ohio.

THE PRESIDENT.—I declare the seventy-sixth annual meeting of the American Medico-Psychological Association now in session. Will you please rise while Divine blessing will be invoked by the Very Rev. Francis S. White of Trinity Cathedral, Cleveland, Ohio.

The invocation was then offered.

THE PRESIDENT.—We are fortunate in having with us a young Mayor, who, in one short month, has been able to clean up the City morally. The gates of the City will be thrown open by the Hon. W. S. Fitzgerald, Mayor of Cleveland.

MAYOR FITZGERALD.—*Ladies and Gentlemen:* It affords me distinct pleasure to officially extend to you today the welcome of the City of Cleveland, and to express to you the hope that your convention will be a successful one, and that your visit to our City will be most pleasant.

While we are proud of the material greatness of Cleveland, and while we have a certain degree of self-satisfaction in the variety of its industries and its importance as an industrial and commercial center, yet, I think we are prouder still of the fact that the city has a certain degree of Civic conscience, and is beginning to realize that these great centers of population we call cities are not mere congregations of human beings interested mostly in selfish gain and advancement, but that there is a certain note of conscience that can be heard above the roar of the machinery of industry and commerce, and that as we progress materially the city will endeavor to progress spiritually.

I hope it will be convenient for you delegates to visit some of our welfare institutions. A few weeks ago the voters of this city very generously awarded to the city government \$3,500,000 to extend the present City Hospital facilities. The buildings which are now being used for this most important work are somewhat antiquated, but the staff of physicians and surgeons which practically controls the public hospital in

Cleveland, is one of the finest in the country. These men and women, foremost in their professions, have given generously of their time in order to make the City Hospital of Cleveland one of the best institutions of its kind.

I hope, also, you will find it convenient to visit the public institutions at Warrensville, and see the work that is being done there for the care of the tubercular patients and for those who are feeble-minded.

I think when you leave Cleveland you will take away with you the thought that we want to do a little more here than the strict letter of the law demands in the way of welfare work and care for the sick and unfortunate.

Mr. Chairman, if there is any way in which I can co-operate with you and the other officers of this convention in extending courtesies or assistance to the delegates, you have only to command. I again accord you and the members of this Association the hearty welcome of the City of Cleveland. (Applause.)

THE PRESIDENT.—I regret to say that up to the present time our speaker who was to welcome us on the part of the State, is not here. We hope he may be here a little later.

However, we have with us a gentleman of whom we all are very proud. A nice little tribute was paid to this gentleman a few years ago. Possibly you may remember, some of you, that we had a little "scrap" over the seas a short time ago. When the Ambassador to France returned the members of the Union Club gave a banquet in his honor. In response to a call, Governor Herrick told this little story: He said that at a dinner he attended in Paris just prior to his leaving for home, the name of Dr. Crile was spoken a great many times, when a layman (he must have been a layman or he would never have asked the question) got up and said: "Who is this Dr. Crile that you are talking so much about?" Dr. Duchenne, of New York, got up and said, "I'll tell you who Dr. Crile is; Dr. Crile is one of two or three of the greatest surgeons in the world"; when Dr. Regis rose to his feet and said, "You are wrong my friend, I will tell you who Dr. Crile is; he is *the very greatest* surgeon in the world." It was my pleasure to teach in the same school with Dr. Crile for several years, and as I took great pleasure in being associated with him, I now take great pleasure in introducing him to you. *Dr. Crile.*

DR. CRILE.—During the war in the comparative leisure of a return trip to Europe on the SS. St. Paul, I had the good fortune to meet a distinguished member of your society, who gave me my first insight into the modern work of the psychiatrist. This introduction interested me so greatly that I was keen to avail myself of opportunities to see something of the work of the American and the Allied psychiatrists during the war.

It therefore gives me a peculiar pleasure to avail myself of this opportunity to pay my sincerest tribute to your achievements in the war. My estimate of the value of the work of the psychiatrists in the war would place it first among the achievements of the Medical Department of the Army.

Sanitation and preventive medicine and surgery as practiced in the war represented fairly well what had been previously known. But by your war experience and that of your confreres it would seem that psychiatry and psychology have been placed on the secure foundation of biology and bio-physics. After all, the mind of man is approximately all that is worth while and the responsibility of psychiatry is proportionately great.

As the spokesman on this occasion for the medical profession of Cleveland; for the medical institutions and hospitals of Cleveland; and for the medical school of Cleveland, I bid you a hearty welcome. We are honored by your presence; we respect the great work you have done in war and in peace; we believe this is merely an earnest of the greater work that lies before you.

I trust that your too brief sojourn with us will be pleasant; you do not need my assurance that our institutions and ourselves are wholly at your disposal. Once again, a hearty welcome to Cleveland. (Applause.)

THE PRESIDENT.—In responding to these words of welcome it seems as though it were better if I were to give you a welcome, as this is my home city. We do appreciate the very great cordiality you have shown us, and I, also, extend a welcome to the delegates of this convention. Speaking of keys—there are no keys to this City, and no locks; the latch-string always hangs out in the City of Cleveland for you. (Applause.)

We will now have a report from the Committee of Arrangements, of which Dr. Drysdale is Chairman.

REPORT OF COMMITTEE OF ARRANGEMENTS.

Mr. President, your committee of arrangements desires to report that Cleveland has shown a lively interest in your first visit to our fair city, and heartily bids you welcome.

Dr. W. A. Searl, our treasurer, has succeeded in obtaining from the private institutions and psychiatrists of the State a fund of \$600, and this will be utilized for your pleasure and comfort.

Dr. Guy Williams has assumed charge of the registration department, and with his assistants stands ready to render any service that may be necessary. May I urge that all members and guests register and obtain their official badges at as early an hour as possible?

The Statler Hotel deserved unstinted praise for the manner in which it has co-operated with your committee. They have given us "open house" and have overlooked nothing that might add to our convenience.

Its location is in the heart of the retail business and theatre section, and I may add that the ladies will be invited to inspect our leading business houses on Thursday and Friday mornings.

Tomorrow (Wednesday) the ladies will be entertained with an automobile journey through Wade, Rockefeller and Gordon Parks, with a stop-over at the Cleveland Museum of Art. Director Whiting has generously allotted one of his assistants to accompany the party through his excellent institution. Dr. Katherine Moses will be hostess on this occasion, and all those desirous of making the trip will please communicate with her at the registration booth, this morning, as a chauffeur's strike is in progress and we may have difficulty in obtaining sufficient cars unless we know in advance how many are going.

Dr. George W. Crile has courteously offered to demonstrate some interesting laboratory work on the brain, and you are also welcome to attend this operative clinic (goiter cases) tomorrow morning at eight o'clock at Lakeside Hospital. Dr. C. B. Burr is arranging a party and those interested might do well to get in touch with him. The hospital is just three blocks north of the Statler. The Superintendent of the Cleveland State Hospital, Dr. G. H. Williams, is also prepared to greet those desirous of visiting his institution.

Wednesday evening, President McMaster of Mt. Union College, will deliver the Annual Address. This will be followed by the President's reception; then the floor will be cleared for dancing. Refreshments have been provided for, and our leading orchestra will be on hand to do the rest.

Legally, the city is dry—bone dry—but I understand official prescriptions are available for psychiatric purposes.

If there are any "golf bugs" among you, your cravings may be satisfied if you will kindly leave your correct club handicaps with the registration officer.

Your committee has undertaken the task of providing for your entertainment with keen pleasure. We are honored to have the privilege of greeting you for the first time in Cleveland. We heartily trust that the seventy-sixth session of the American Medico-Psychological Association will prove a most interesting and profitable one, and that you will return home with a desire to come again.

H. H. DRYSDALE, *Chairman,*
Committee of Arrangements.

THE PRESIDENT.—I will now ask the Secretary to read the report of the Council.

REPORT OF THE COUNCIL TO THE AMERICAN MEDICO-PSYCHOLOGICAL
ASSOCIATION.

CLEVELAND, June 1, 1920.

The Council met on the evening of May 31, at the Hotel Statler, Cleveland, Ohio.

The Council recommends for election to active membership the following named physicians. This list was presented to the Association a year ago and these names are now submitted for final consideration:

Ernest S. Bagby, M.D., Supply, Okla.; M. Carroll Baines, M.D., Philadelphia, Pa.; Wm. M. Bevis, M.D., Chattahoochee, Fla.; Anne T. Bingham, M.D., New York, N. Y.; Burton A. Black, M.D., Polk, Pa.; Max H. Bochroch, M.D., Philadelphia, Pa.; Walter G. Bowers, M.D., Schuylkill Haven, Pa.; Willis W. Carey, M.D., Ft. Wayne, Ind.; Harry R. Carson, M.D., Pineville, La.; Howard W. Cleasby, M.D., Lancaster, N. H.; Thomas J. Cummins, M.D., Phoenix, Ariz.; Francis X. Dercum, M.D., Philadelphia, Pa.; Antoine H. Desloges, M.D., Montreal, Can.; Ambrose F. Dowd, M.D., Newark, N. J.; Ruth E. Fairbank, M.D., Jacksonville, Ill.; Samuel F. Gordon, M.D., Philadelphia, Pa.; Charles F. Graham, M.D., Wytheville, Va.; Phyllis Greenacre, M.D., Baltimore Md.; Ward W. Hedlund, M.D., Ingleside, Neb.; Leslie B. Hohman, M.D., Baltimore, Md.; Samuel R. Holroyd, M.D., Spencer, W. Va.; George E. Hosner, M.D., Camp Bowie, Tex.; Matthew J. L. Hoyer, M.D., Meridian; Miss.; Emilie C. Jamison, M.D., Ward's Island, N. Y.; Robert A. Keilty, M.D., Danville, Pa.; Kenneth W. Kinney, M.D., Washington, D. C.; Joseph V. Klauder, M.D., Philadelphia, Pa.; Frank E. Leslie, M.D., Andover, Mass.; John L. VanDeMark, M.D., Albany, N. Y.; Alvin T. Mathers, M.D., Winnipeg, Man.; Karl A. Menninger, M.D., Topeka, Kans.; Abraham Myerson M.D., Boston, Mass.; John R. Oliver, M.D., Baltimore, Md.; Esther L. Richards, M.D., Baltimore, Md.; Ward Sampson, M.D., New York, N. Y.; Augusta Scott, M.D., Baltimore, Md.; R. E. Lee Smith M.D., Bearden, Tenn.; Frank R. Starkey, M.D., Detroit, Mich.; Charles B. Sullivan, M.D., Boston, Mass.; Albert C. Thomas, M. D., Foxboro, Mass.; Raymond F. Wafer, M. D., Ann Arbor, Mich.; Thomas D. Woodson, M. D., M. C., U. S. A.; George J. Wright, M. D., New York, N. Y.

The Council recommends the transfer of the following named associate members to the active class:

Leland B. Alford, M.D., St. Louis, Mo.; Frank S. Bachelder, M.D., Pontiac, Mich.; Edgar C. Barnes, M.D., Selkirk, Man.; Myrtelle M. Canavan, M.D., Boston, Mass.; Fred J. Conzelmann, M.D., Stockton, Cal.; Gilbert F. Douglas, M.D., Birmingham, Ala.; A. B. Eckerdt, M.D., Warm Springs, Mont.; Howard M. Francisco, M.D., Nashville, Tenn.; H. G. Gibson, Jr., M.D., Central Islip, N. Y.; Bernard Glueck, M.D., New York, N. Y.; James C. Hassall, M.D., Cuyahoga Falls, O.; M. C. Hawley, M.D., East Moline, Ill.; Louis K. Henschel, M.D., Newark, N. J.; Morgan B. Hodskins, M.D., Palmer, Mass.; C. S. Holbrook, M.D., New Orleans, La.; Harry W. Keatley, M.D., Baltimore, Md.; Walter E. Lang, M.D., Westbrough, Mass.; Samuel C. Lindsay, M.D., Cleveland, O.; Alexander R. MacKenzie, M.D., Huntington, W. Va.; Joseph W. Moore, M.D., Beacon, N. Y.; Mary E. Morse, M.D., Baltimore, Md.; Marian O'Harrow, M.D., Valley City, N. Dak.; William C. Porter, M.D., Columbus Barracks, Ohio; F. W. Quin, M.D., McDonaghville, La.; Harry S. Seiwel, M. D., Kankakee, Ill.; George A. Sharp, M. D., Beacon,

N. Y.; R. Sheehan, M.D., New York, N. Y.; Henry C. Smith, M.D., Cedar Grove, N. J.; Earl H. Snavely, M.D., Cedar Grove, N. J.; A. Warren Stearns, M.D., Billerica, Mass.; Edward A. Strecker, M.D., West Philadelphia, Pa.; Roger C. Swint, M.D., Milledgeville, Ga.; Charles W. Thompson, M.D., Pueblo, Colo.; J. L. Thompson, M.D., Columbia S. C.; Joseph H. Toomey, M.D., Washington, D. C.; A. A. Thurlow, M.D., Eldridge, Cal.; John H. Travis, M.D., Augusta, Me.; Nelson C. Trueman, M.D., Salem, Mass.; Stephen E. Vosburgh, M.D., West Pownall, Me.; Walter J. Otis, M.D., New Orleans, La.

The Council recommends that the following named physicians be elected to associate membership in the Association:

Ralph M. Chambers M.D., Westborough, Mass.; Neil A. Dayton, M.D., Westborough, Mass.; Glenn J. Doolittle, M.D., Sonyea, N. Y.; Emma H. Fay, M.D. Westborough, Mass.; Alma E. Fowler, M.D., Taunton, Mass.; R. Finley Gayle, Jr., M.D., Richmond, Va.; Robert B. Harriman, M.D., Worcester, Mass.; Roy C. Jackson, M.D., Worcester, Mass.; Katherine R. Moses, M.D., Cleveland, O.; Arthur H. Mountford, M.D., Worcester, Mass.; Harry S. Newcomer, M.D., Philadelphia, Pa.; Arthur M. Phillips, M.D., Ward's Island, N. Y.; Nicholas W. Pinto, M.D., Kalamazoo, Mich.; Evelyn B. Price, M.D., Pueblo, Colo.; Michael J. Shealey, M.D., Westborough, Mass.; Albert Smith, M.D., Washington, D. C.; Effie A. Stevenson M.D., Hathorne, Mass.; Phillip J. Trentzsch, M.D., Washington, D. C.; Wm. J. Vivian, M.D., Worcester, Mass.; Harney M. Watkins, M.D., Palmer, Mass.; Alfred T. Wood, M.D., Kings Park, N. Y.

The Council has received and considered the applications of the following named physicians for active membership in the Association. In accordance with the provision of the constitution, final consideration will be deferred until next year:

Max A. Bahr, M.D., Indianapolis, Ind.; John H. Berry, M.D., Athens, O.; Richard Blackmore, M.D., Norwich, Conn.; James M. Beeler, M.D., Columbia, S. C.; Wm. M. Faulk, M.D., Tuscaloosa, Ala.; Don P. Flagg, M.D., Los Angeles, Cal.; Justin K. Fuller, M.D., Washington, D. C.; Ransom A. Greene, M.D., East Gardner, Mass.; J. Allison Hodges, M.D., Richmond, Va.; Walter B. Jennings, M.D., Stamford, Conn.; John A. Lichty, M.D., Pittsburgh, Pa.; Robert M. Mitchell, M.D., Weyburn, Sask., Canada; Clarence A. Patten, M.D., Philadelphia, Pa.; George K. Pratt, M.D., Flint, Mich.; Irving J. Sands, M.D., Brooklyn, N. Y.; Charles W. Stone, M.D., Cleveland, O.; Henry C. Szeto, M.D., Ward's Island, N. Y.; Kenn B. Uhls, M.D., Overland Park, Kans.; George L. Wallace, M.D., Wrentham, Mass.; Clement P. Wescott, M.D., Portland, Me.; Malcolm S. Woodbury, M.D., Clifton Springs, N. Y.; Edmund M. Connely, M.D., New Orleans, La.

The Council has received the resignations of the following members, and recommends that they be accepted:

Helen Taft Cleaves, M.D., Pacific Grove, Cal.; F. N. Maginnis, M.D., Aurora, Ill.; Annie Austin Young, M.D., Anderson, S. C.; E. S. Burdsall, M.D., Patton, Cal.; Albert Durham, M.D., Charlotte, N. C.; Charles E. Stanley, M.D., Middletown, Conn.; Thomas E. Bamford, M.D.,

Syracuse, N. Y.; Charles Ricksher, M.D., Kankakee, Ill.; David A. Shirres, M.D., Montreal, Canada.

The Council recommends that the dues for the ensuing year be fixed at the usual rates, viz., \$5.00 for active members, and \$2.00 for associate members.

Respectfully submitted,

H. W. MITCHELL, *Secretary*.

THE PRESIDENT.—What will you do with this report? As far as the election of members is concerned, that will be deferred until tomorrow, but the remainder of the report may be acted upon.

DR. C. B. BURR.—I move that the balance of the report be accepted and adopted, and that the resignations contained therein be accepted.

This motion was duly seconded and carried.

THE PRESIDENT.—We will now hear the Treasurer's report. Unless there is objection, this report may be read by totals.

REPORT OF THE SECRETARY-TREASURER.

The following is a statement of membership of the American Medico-Psychological Association to date, June, 1920.

HONORARY MEMBERS.

Former number	16	
Added	2	
Total	18	
Died	5	
Present number		13

LIFE MEMBERS.

Former number	32	
Added	8	
Total	40	
Died	3	
Present number		37

ACTIVE MEMBERS.

Former number	508	
Associate to Active	80	
Admitted	28	
Total	616	
Active to Life	8	
Resigned	3	
Dropped	11	
Died	6	
Total	28	
Present number		588

ASSOCIATE MEMBERS.

Former number	355	
Admitted	40	
		<hr/>
Total		395
Associate to Active	80	
Resigned	6	
Dropped	14	
Died	0	
		<hr/>
Total		100
Present number		295
		<hr/>
Grand total membership, May 30, 1920.....		933

REPORT OF TREASURER, 1919-1920.

June 6, 1919, Balance in active account.....\$798.15

RECEIPTS.

For dues:

Active members	\$2,835.00
Associate members	487.00
Miscellaneous:	
Gummed lists of members.....	\$8.45
Boston State Hospital for Transactions.....	16.00
	<hr/>

Total receipts	3,346.45
Total debits	\$4,144.60

1919

CREDITS.

June 30	Margaret Bloxham, expense account.....	\$45.74
July 1	Lord Baltimore Press, printing membership lists.....	265.27
	George L. Folkman, additions to service flag.....	16.15
24	Wm. R. Dunton, Jr., proof reading and index work....	11.50
Aug. 27	Harvey N. Cushing, honorarium	50.00
Nov. 12	T. W. Evans, M. D., refund 1918 dues.....	2.00
27	John T. Newell, printing, stamped envelopes, etc.....	58.94
	Henry Schindler, printing receipt book.....	42.25
Dec. 13	Margaret Bloxham, reporting 1919 meeting.....	100.00
	John T. Newell, printing circular letters.....	4.75
20	H. J. Schindler, envelopes.....	7.75
	Lord Baltimore Press, <i>Transactions</i>	1,673.37
22	Alice E. Sill, clerical service.....	60.00

1920

Jan. 22	H. W. Mitchell, M. D., expense account.....	\$29.05
Feb. 19	H. A. Ross, stamps.....	20.00
Mar. 17	Thos. E. Banford, M. D., refund 1919 dues.....	7.00
23	H. A. Ross, stamps.....	20.00
May 4	John T. Newell, printing, envelopes, etc.....	18.75
	Western Union Telegraph Co., message charges.....	7.39
	Alice E. Sill, clerical service.....	85.00
7	H. A. Ross, stamps.....	20.00
12	Hoff Business College, circular letters.....	1.75
15	Lord Baltimore Press, 1920 membership lists.....	549.43
15	H. W. Mitchell, M. D., express and telegrams.....	2.26
21	Eline S. Noble, clerical service.....	20.00
26	John T. Newell, printing programs.....	95.50

3,203.85

June 1 Balance on hand, active account..... 940.75

\$4,144.60

1920

June 1 Cash balance:

Active account	\$940.75
Interest account	1,218.00
Interest from June 1, 1919, to June 1, 1920.....	49.20

Total cash on hand June 1, 1920.....\$2,207.95

Respectfully submitted,

H. W. MITCHELL, *Treasurer.*

THE PRESIDENT.—A. motion to refer the Treasurer's Report to the auditors is in order.

DR. RICHARD DEWEY.—I move the report be so referred.

Motion carried.

THE PRESIDENT.—The next business in order will be the report of the editors of THE AMERICAN JOURNAL OF INSANITY, Dr. Brush.

REPORT OF THE EDITORS OF THE AMERICAN JOURNAL OF INSANITY.

To the Members of the American Medico-Psychological Association:
The editorial board of the JOURNAL wish the JOURNAL to speak for itself. You know what it has been during the past year and if you have any criticisms to make or any suggestions to offer we will gladly receive them. The cost of publication has materially increased and is likely to still further increase. Members who contribute papers can help in keeping down the cost by presenting their papers in such shape that they can be readily put in type and by refraining from making alterations in proof beyond those necessary to correct errors. Some contributors have in the past partly

re-written their articles after they were in type necessitating many changes, at considerable expense. You are earnestly requested not to do this. The financial report accompanying this report shows a comfortable balance, but this may be seriously decreased by increasing costs of publication.

Respectfully submitted,

EDWARD N. BRUSH.

Motion was seconded and carried that the financial part of the report of the Editors of the AMERICAN JOURNAL OF INSANITY be referred to the Auditors.

THE PRESIDENT.—I will call for the report of the Committee on War Work.

REPORT OF WAR WORK COMMITTEE.

The fortunate ending of the World War terminated every active function of this committee soon after its formation. Since the last meeting, it has endeavored to secure the war record of members for insertion in the *Transactions*. After much correspondence, this work appears to be completed so far as the committee can secure replies from members. The record as compiled will be printed in the 1920 *Transactions* and the committee submits this report with the request that it be discharged.

H. W. MITCHELL, M. D., *Chairman*, Warren, Pa.,
WM. L. RUSSELL, M. D., White Plains, N. Y.,
FRANKWOOD E. WILLIAMS, M. D., New York, N. Y.,
EDITH R. SPAULDING, M. D., New York, N. Y.,
GEO. M. KLINE, M. D., Boston, Mass.,
WM. A. WHITE, M. D., Washington, D. C.,
C. B. BURR, M. D., Flint, Mich.

THE PRESIDENT.—With the publication of their report, the War Work Committee asks to be discharged; what is the sense of the Association in this matter?

DR. DEWEY.—I move that the War Work Committee be discharged.

DR. BRUSH.—I know what a tremendous task the chairman of the War Work Committee has carried out, and I move in addition that the thanks of the Association be extended to this Committee.

This motion was as amended seconded and unanimously carried.

THE PRESIDENT.—It now becomes my duty to appoint a Nominating Committee. I will name the following on this committee: Charles G. Wagner, M. D., New York; C. B. Burr, M. D., Michigan; Charles H. Clark, M. D., Ohio.

At this point, according to the program, there is a recess for registration of members and visitors, but this has not been done for several years, and is not necessary.

The following members registered and were in attendance during the whole or a part of the meeting:

Abbot, E. Stanley, M. D., Medical Director Mental Hygiene Committee, Public Charities Assn., 403 Empire Bldg., Philadelphia, Pa.

Abbot, Florence H., M. D., Asst. Physician Boston State Hospital, Mattapan, Mass.

Adler, Herman M., M. D., State Criminologist Dept. of Public Welfare, 1812 W. Polk St., Chicago, Ill.

Alford, Leland B., M. D., Associate in Neurology Worthington University Medical School, Barnes Hospital, St. Louis, Mo.

Allen, H. D., M. D., Superintendent Allen's Invalid Home, Milledgeville, Ga.

Anderson, Albert, M. D., Superintendent State Hospital, Raleigh, N. C.

Anderson, V. V., M. D., Associate Med. Director National Committee for Mental Hygiene, 50 Union Square, New York, N. Y.

Ashley, M. C., M. D., Superintendent State Hospital, Middletown, N. Y.

Baber, Armitage, M. D., Superintendent Dayton State Hospital, Dayton, Ohio.

Baines, M. C., M. D., First Assistant Norristown State Hospital, Norristown, Pa.

Bancroft, Chas. P., M. D., Chairman Board of Trustees N. H. State Hospital, Concord, N. H.

Barrett, Albert M., M. D., Prof. of Psychiatry and Neurology, University Hospital, Ann Arbor, Mich.

Bass, T. B., M. D., Superintendent State Epileptic Colony, Abilene, Tex.

Becker, W. F., M. D., Prof. Psychiatry Marquette University, 604 Goldsmith Bldg., Milwaukee, Wis.

Belyea, James A., M. D., Manager Toledo Sanitarium, Toledo, Ohio.

Berry, John H., M. D., Superintendent Athens State Hospital, Athens, Ohio.

Beutler, W. F., M. D., Superintendent Milwaukee Asylum for Mentally Diseased, Waukatosa, Wis.

Blumer, G. A., M. D., Physician-in-Chief and Superintendent Butler Hospital, Providence, R. I.

Bond, Earl D., M. D., Medical Director Pennsylvania Hospital, Dept for Mental and Nervous Dis., 4401 Market St., Philadelphia, Pa.

Braunlin, Edgar L., M. D., 920 Fidelity Bldg., Dayton, O.

Brennan, Thomas P., M. D., Instructor, Iowa State Psychopathic Hospital, Iowa City, Iowa.

Brewster, George F., M. D., Surgeon U. S. P. H. S., 442 Putnam Ave., Brooklyn, N. Y.

Brown, G. W., M. D., Superintendent Eastern State Hospital, Williamsburg, Va.

Brown, Sanger, M. D., Chief-of-Staff Kenilworth Sanitarium, Kenilworth, Ill.

Brown, Sanger, II, M. D., Neurological Institute, 37 W. 54th St., New York, N. Y.

Brush, Edward N., M. D., Superintendent Emeritus Sheppard and Enoch Pratt Hospital, Baltimore, Md.

Buckley, Albert C., M. D., Superintendent Friends Hospital, Frankford, Philadelphia, Pa.

Burr, C. B., M. D., Formerly Medical Director Oak Grove, Drawer 27, Flint, Mich.

Chapman, Ross McC., M. D., Superintendent Sheppard & Enoch Pratt Hospital, Towson, Md.

Cheney, Clarence O., M. D., Asst. Director Psychiatric Institute, Ward's Island, New York City.

Church, Mary V., Asst. Physician Massillon State Hospital, Massillon, Ohio.

Clark, Charles H., M. D., Superintendent Lima State Hospital, Lima, Ohio.

Clark, Fred P., M. D., Superintendent Stockton State Hospital, Stockton, Calif.

Cphoon, E. H., M. D., Superintendent Westfield State Hospital, Harding, Mass.

Cook, R. Harvey, M. D., Superintendent Oxford Retreat, Oxford, O.

Copp, Owen, M. D., Physician-in-Chief and Administrator Pennsylvania Hospital, Dept. for Nerv. & Mental Dis., 4401 Market St., Philadelphia, Pa.

Cornell, W. B., M. D., Mental Diagnostician University of the State of New York, Albany, N. Y.

Cozad, H. Irving, M. D., Physician-in-Charge Sanitarium, Cuyahoga Falls, Ohio.

Creed, C. H., M. D., Asst. Physician Columbus State Hospital, Columbus, Ohio.

Curry, Marcus A., M. D., Superintendent N. J. State Hospital, Morris Plains, N. J.

Darling, Ira A., M. D., Sr. Asst. Physician Warren State Hospital, Warren, Pa.

Deuschle, W. D., M. D., Mt. Carmel Hospital, Columbus, Ohio.

Devlin, F. E., M. D., Superintendent St. Jean de Dieu Hospital, Montreal, Canada.

Dewey, Richard, M. D., Medical Director Milwaukee Sanitarium, Wauwatosa, Wis.

Dobson, W. M., M. D., Surgeon U. S. P. H. S., Hospital No. 39, Hoboken, Pa.

Doloff, Chas. H., M. D., Superintendent N. H. State Hospital, Concord, N. H.

Drewry Wm. F., M. D., Superintendent Central State Hospital, Petersburg, Va.

Drysdale, H. H., M. D., Neurologist, Cleveland, Ohio.

Dunham, Sydney A., M. D., Parkside Sanitarium, 1392 Amherst St., Buffalo, N. Y.

Dunton, W. R., Jr., M. D., Asst. Physician Sheppard & Enoch Pratt Hospital, Towson, Md.

Eckel, John L., M. D., Buffalo, N. Y.

- Edgerly, J. F., M. D., Superintendent Sherwood, Lincoln, Mass.
- Elder, C. T., M. D., Superintendent Ohio Sanitarium Co., 14822 Terrace Road, East Cleveland, Ohio.
- Emerick, E. J., M. D., Superintendent Institution for Feeble-Minded, Columbus, O.
- English, W. M., M. D., Superintendent Ontario Hospital, Hamilton, Canada.
- Eyman, Henry C., M. D., Massillon, Ohio.
- Faison, W. W., M. D., Superintendent State Hospital, Goldsboro, N. C.
- Farmer, W. Scott, M. D., Superintendent Central State Hospital, Nashville, Tenn.
- Finlayson, Alan D., M. D., 2677 E. 128th St., Cleveland, O.
- Fordyce, O. O., M. D., Superintendent Toledo State Hospital, Toledo, Ohio.
- Forster, J. M., M. D., Superintendent Ontario Hospital, Whitby, Ont., Canada.
- Francisco, H. M., M. D., Surgeon U. S. P. H. S., Washington, D. C.
- Fernald, Walter E., M. D., Superintendent Massachusetts School for Feeble-Minded, Waverley, Mass.
- Gable, J. J., M. D., Clinical Director Central Okla. State Hospital, Norman, Okla.
- Gahagan, Henry J., M. D., Medical Director Mercyville Sanitarium, Aurora, Ill., 122 S. Michigan Boulevard, Chicago, Ill.
- Gosline, Harold I., M. D., Pathologist State Hospital, Howard, R. I.
- Goss, Arthur V., M. D., Superintendent Taunton State Hospital, Taunton, Mass.
- Green, E. M., M. D., Superintendent Pa. State Lunatic Hospital, Harrisburg, Pa.
- Gregg, Donald, M. D., Associate Physician Channing Sanitarium, Wellesley, Mass.
- Gundry, Richard F., M. D., Med. Director The Richard Gundry Home, Catonsville, Md.
- Guthrie, L. V., M. D., Superintendent Huntington State Hospital, Huntington, W. Va.
- Hall, J. K., M. D., Med. Director Westbrook Sanitarium, Richmond, Va.
- Halroyd, Samuel R., M. D., Superintendent Spencer State Hospital, Spencer, W. Va.
- Hamilton, G. V., M. D., Santa Barbara, Cal.
- Hamilton, Samuel W., M. D., Associate Med. Director National Committee for Mental Hygiene, 50 Union Square, New York City.
- Harding, Geo. T., Jr., M. D., The Columbus Rural Rest Home, 318 E. State St., Columbus, Ohio.
- Harris, Isham, G., M. D., Superintendent Brooklyn State Hospital, Brooklyn, N. Y.
- Haskell, Robert H., Superintendent Ionia State Hospital, Ionia, Mich.
- Hassall, James C., M. D., Clinical Psychiatrist Fair Oaks Villa, Cuyahoga Falls, Ohio.

Haviland, C. Floyd, M. D., Superintendent Connecticut State Hospital, Middletown, Conn.

Hedin, Carl J., M. D., Superintendent Bangor State Hospital, Bangor, Me.

Houston, John A., M. D., Superintendent Northampton State Hospital, Northampton, Mass.

Howard, Adams B., M. D., 836 Rose Building, Cleveland, Ohio.

Hubbard, O. S., M. D., Superintendent State Hospital for Epileptics, Parsons, Kans.

Hulbert, H. S., M. D., Asst. Physician Chicago State Hospital, 328 S. Euclid Ave., Oak Park, Ill.

Hutchings, Richard H., M. D., Superintendent Utica State Hospital, Utica, N. Y.

Hyde, Arthur G., M. D., Superintendent Massillon State Hospital, Massillon, Ohio.

Ingram, Robert, M. D., Cincinnati General Hospital, Cincinnati, Ohio.

Jones, L. M., M. D., Superintendent Georgia State Sanitarium, Milledgeville, Ga.

Kauffman, Lesser, M. D., Asso. Prof. Neurology, University of Buffalo, 534 Elmwood Ave., Buffalo, N. Y.

Kempf, E. J., M. D., Clinical Psychiatrist St. Elizabeths Hospital, Washington, D. C.

Kidd, R. A., M. D., Superintendent McMillen Sanitarium, Shepard, Ohio.

Kieb, Raymond F. C., M. D., Superintendent Matteawan State Hospital, Beacon N. Y.

Kilbourne, Arthur F., M. D., Superintendent Rochester State Hospital, Rochester, Minn.

Kineon, G. G., M. D., Superintendent Ohio Hospital for Epileptics, Gallopis, Ohio.

King, George W., M. D., Superintendent Hudson County Hospital, Secaucus, N. J.

Kirk, C. C., M. D., Superintendent State Hospital, Little Rock, Ark.

Kline, George M., M. D., Dept. of Mental Diseases, State House, Boston, Mass.

Klopp, Henry I., M. D., Superintendent Homeopathic State Hospital, Allentown, Pa.

LaMoure, Charles T., M. D., Superintendent Mansfield State Training School & Hospital, Mansfield Depot, Conn.

LaMoure, H. A., M. D., Superintendent Colorado State Hospital, Pueblo, Colo.

Lang, Walter E., M. D., Superintendent Westborough State Hospital, Westborough, Mass.

Laughlin, C. E., M. D., Superintendent So. Indiana Hospital for Insane, Evansville, Ind.

Lewis, J. M., M. D., 10921 Wade Park Ave., Cleveland, Ohio.

Lindsay, S. C., M. D., 1110 Euclid Ave., Cleveland, Ohio.

Lowrey, Lawson G., M. D., Asst. to Director Psychopathic Hospital, Iowa City, Ia.

- Ludlum, S. D., M. D., Philadelphia Hospital, Gladwyne, Pa.
- McNairy, C. Banks, M. D., Superintendent The Caswell Training School for Mental Defectives, Kinston, N. C.
- Mason, G. Henry, M. D., Worcester, Mass.
- May, James V., M. D., Superintendent Boston State Hospital, Boston, Mass.
- Mayer, Edward E., Assoc. Prof. Psychiatry, Pittsburg, Pa.
- Mitchell, H. W., M. D., Superintendent State Hospital, Warren, Pa.
- Moody, T. L., M. D., Superintendent Dr. Moody's Sanitarium, San Antonio, Texas.
- Moses, Katharine R., M. D., Asst. Physician Cleveland State Hospital, Cleveland, Ohio.
- Moynan, Richard S., M. D., Asst. Physician Cleveland State Hospital, Cleveland, Ohio.
- Munnerlyn, J. F., M. D., Med. Director S. C. State Hospital, Columbia, S. C.
- Murdoch, J. M., M. D., Superintendent State Institution for Feeble-Minded, Polk, Pa.
- Nairn, B. Ross, M. D., Surgeon U. S. P. H. S. Hospital, Cape May, N. J.
- Norbury, Frank P., M. D., Med. Director Norbury Sanitarium, Jacksonville, Ill.
- North, Emerson A., M. D., Superintendent Longview Hospital, Cincinnati, Ohio.
- O'Brien, John D., M. D., Canton, Ohio.
- Orton, Samuel T., M. D., Medical Director Psychopathic Hospital, Iowa City, Iowa.
- Ostrander, Herman, M. D., Superintendent Kalamazoo State Hospital, Kalamazoo, Mich.
- Parsons, Frederick W., M. D., Superintendent Buffalo State Hospital, Buffalo, N. Y.
- Payne, Guy, M. D., Superintendent Essex County Hospital, Cedar Grove, N. J.
- Potter, Clarence A., M. D., Superintendent Gowanda State Hospital, Collins, N. Y.
- Potter, F. C., M. D., Pathologist State Hospital, Kalamazoo, Mich.
- Priddy, A. S., M. D., Superintendent State Colony for Epileptics and Feeble Minded, Colony P. O., near Lynchburg, Va.
- Pritchard, Wm. W., M. D., Superintendent Columbus State Hospital, Columbus, Ohio.
- Purdum, Harry D., M. D., Springfield State Hospital, Sykesville, Maryland.
- Raeder, Oscar J., M. D., Asst. Pathologist Mass. Dept. Mental Diseases, 74 Fenwood Road, Boston, Mass.
- Ratliff, Thomas A., M. D., Res. Physician Grandview Sanitarium, Cincinnati, Ohio.
- Read, Charles F., M. D., Managing Officer Chicago State Hospital, Chicago, Ill.

Richardson, W. W., M. D., Med. Director Mercer Sanitarium, Mercer, Pa.
Robinson, W. J., M. D., Superintendent Ontario Hospital, London, Ont., Canada.

Rogers, C. B., M. D., Res. Med. Director Cincinnati Sanitarium, Cincinnati, Ohio.

Ross, Chas. E., M. D., Consultant, Wichita, Kans.

Ross, John R., M. D., Superintendent Dannemora State Hospital, Dannemora, N. Y.

Russell, William L., M. D., Superintendent Bloomingdale Hospital, White Plains, N. Y.

Rutherford, Thomas A., M. D., Superintendent Hillside Home, Scranton Hospital for the Insane, Clarks Summit, Pa.

Ryon, Walter G., M. D., Superintendent Hudson River State Hospital, Poughkeepsie, N. Y.

Salmon, Thomas W., M. D., Med. Director National Committee for Mental Hygiene, 50 Union Square, New York City.

Saunders, Eleanora B., M. D., Physician Sheppard & Enoch Pratt Hospital, Towson, Md.

Sawyer, Carl W., M. D., Sawyer Sanitarium, Marion, Ohio.

Searl, W. A., M. D., Med. Director Fair Oaks Villa, Cuyahoga Falls, Ohio.

Singer, H. Douglas, M. D., State Alienist Dept. Public Welfare Illinois State Psychopathic Institute, Dunning, Ill.

Sleyster, Rock, M. D., Superintendent Milwaukee Sanitarium, Wauwatosa, Wis.

Smith, Groves Blake, M. D., Asst. School for Nervous and Backward Children, Godfrey, Ill.

Smith, Henry G., M. D., Asst. Physician Essex County Hospital, Cedar Grove, N. J.

Smith, H. Mason, M. D., Superintendent Florida State Hospital, Chattahoochee, Fla.

Smith, R. E. Lee, M. D., Superintendent Eastern State Hospital, Bearden, Tenn.

Stearns, A. W., M. D., Med. Director Mass. Com. of Mental Hygiene, Billerica, Mass.

Steward, Wm. J., M. D., Chief Physician State Institution for Feeble Minded of E. Pa., Pennhurst, Pa.

Swift, Henry M., M. D., 645-A Congress St., Portland, Me.

Swint, R. C., M. D., Clinical Director Georgia State Sanitarium, Milledgeville, Ga.

Terhune, Wm. B., M. D., Med. Director Conn. Society of Mental Hygiene, New Haven, Conn.

Thomas, Albert, M. D., Superintendent Foxboro State Hospital, Foxboro, Mass.

Thomas, Jno. N., M. D., Superintendent La Hospital for Insane, Pineville, La.

Truitt, Ralph P., M.D., Med. Director Ill. Society Mental Hygiene, University of Ill. College of Medicine, 2816 S. Michigan Ave., Chicago, Ill.
 Tyson, Forrest C., M.D., Superintendent Augusta State Hospital, Augusta, Me.

Uhls, L. L., M.D., Uhls Sanitarium, Overland Park, Kans.

Wagner, Charles G., M.D., Superintendent Binghamton State Hospital, Binghamton, N. Y.

Walker, Irving L., M.D., Sr. Asst. Physician Rochester State Hospital, Rochester, N. Y.

Weston, Paul G., M.D., Pathologist State Hospital, Warren, Pa.

White, C. E., M.D., Superintendent Weston State Hospital, Weston, W. Va.

Williams, C. F., M.D., Superintendent S. C. State Hospital, Columbia, S. C.

Williams, Guy H., M.D., Superintendent Cleveland State Hospital, Cleveland, Ohio.

Williams, Tom A., M.D., Neurologist to Freedman Hospital, 1621 Conn. Ave., Washington, D. C.

Wiseman, John I., M.D., Clinical Director Conn. State Hospital, Middletown, Conn.

Witte, Max E., M.D., Superintendent Clarinda State Hospital, Clarinda, Iowa.

Work, Hubert, M.D., Superintendent Woodcroft Hospital, Pueblo, Colo.

Wylie, A. R. T., M.D., Superintendent Institution for Feeble-Minded, Grafton, N. Dak.

Young, A. F., M.D., Superintendent Milwaukee Hospital for Mental Diseases, Wauwatosa, Wis.

Yule, Lorne W., M.D., Asst. Physician Cleveland State Hospital, Cleveland, Ohio.

The following visitors and guests of the Association registered their names with the Secretary :

Bass, Mrs. T. B., Abilene, Tex.

Bassett, May Louise, Teacher Fair Oaks Villa, Cuyahoga Falls, Ohio.

Beers, Clifford W., Secretary National Committee for Mental Hygiene, 50 Union Square, New York City.

Belt, Ada C., 2510 E. 55th St., Cleveland, Ohio.

Belt, John H., M.D., 2510 E. 55th St., Cleveland, Ohio.

Berry, Mrs. John H., Matron Athens State Hospital, Athens, Ohio.

Beutler, Mrs. W. F., Wauwatosa, Wis.

Bivin, Geo. Davis, M. A., Ph. D., Medical Psychologist, Chicago, Ill.

Brann, H. W., Cleveland State Hospital, Cleveland, Ohio.

Brelsford, H. H., 636 Rose Bldg., Cleveland, Ohio.

Buckley, Mrs. Albert C., Frankford, Philadelphia, Pa.

Butler, Alice, Pres. Board of Trustees Womans Hospital, Cleveland, Ohio.

Brush, Mrs. Edward N., Baltimore, Md.

Cheney, Mrs. Clarence O., Ward's Island, New York City.

- Copp, Mrs. Owen, 4401 Market St., Philadelphia, Pa.
Curtis, Hannah, Director Social Work Mass. Dept. Mental Diseases, State House, Boston, Mass.
Canter, Margaret, Industrial Teacher Dayton State Hospital, Dayton, Ohio.
Cushman, Mrs. F. H.
Cohoon, Mrs. E. H., Harding, Mass.
Cowden, Anne Hayes, Supervisor Special Classes, Toledo Public School, Toledo, Ohio.
Dunham, Mrs. S. A., Buffalo, N. Y.
Darling, Mrs. Jennie L., Warren, Pa.
Devlin, Mrs. F. E., Montreal, Canada.
Davies, David H., Pres. Board of Administration Asylum for Mental Diseases, Wauwatosa, Wis.
Dabney, Wm. R., Fair Oaks Villa, Cuyahoga Falls, Ohio.
Elwood, Everett S., Secretary State Hospital Commission of New York State, Capitol, Albany, N. Y.
Emrich, E. L., M. D., Asst. Superintendent Hospital for the Insane of Nebr., Norfolk, Nebr.
Evans, Albert, M. D., Secy.-Treas. Hospital Trustees Assn. of Mass., 409 Marlboro St., Boston, Mass.
Fitzgerald, Florence, Assoc. Psycho-Clinician Ohio Bureau Juvenile Research, 80 S. Eureka Ave., Columbus, Ohio.
Fuller, Earl W., Sr. Asst. Phys. Rome State School, Rome, N. Y.
Finlayson, Mrs. A. D., Cleveland, Ohio.
Fry, George C., Boston, Mass.
Fuller, Justin K., M. D., Asst. Surgeon U. S. P. H. S., Washington.
Furbush, Edith M., Statistician Natl. Committee for Mental Hygiene, 50 Union Square, New York.
Goldberg, Jennie, 508 Eagle St., Buffalo, N. Y.
Goldberg, Segismund, Memorial Hospital, Buffalo, N. Y.
Gutberg, I. L., Pres. Ohio Board of Administration, Columbus, Ohio.
Gaum, Clara M., Supervisor State Hospital, Cleveland, Ohio.
Guthrie, Mrs. L. V., Huntington, W. Va.
Goddard, Henry H., Director Bureau Juvenile Research, Columbus, Ohio.
Gurd, Adeline, M. D., Asst. Prof. Neuropathology, Psychopathic Hospital, Ann Arbor, Mich.
Hamilton, Mrs. S. W., New York City.
Harding, Mrs. G. T., Columbus, Ohio.
Hewitt, Mrs. Eaton, Guelph, Ont., Canada.
Hedin, Julia L., Bangor, Maine.
Haviland, Mrs. C. Floyd, Middletown, Conn.
Hays, P. L., Clinical Director E. Okla. State Hospital, Vinita, Okla.
Heydemann, Martin, Physician Mt. Sinai, 2757 Euclid Blvd., Cleveland Heights.
Hansen, Irene T., Special Teacher of Defectives Public Schools, Toledo, Ohio.

- Hughes, Carrie L., Supervisor Amer. Red Cross, Cleveland, Ohio.
 Holroyd, Mrs. S. R., Spencer, W. Va.
 Johnson, W. J., M. D., Superintendent East Texas Hospital for Insane,
 Ruck, Texas.
 Jackson, Miss., Pineville, La.
 Johnson, J. E., Cincinnati, Ohio.
 Kidd, Mrs. R. A., Shepard, Ohio.
 Kieb, Mrs. Raymond F. C., Beacon, N. Y.
 Kline, Mrs. Geo. M., Boston, Mass.
 LaMoure, Mrs. H. A., Pueblo, Colo.
 Laird, George R., Special Rep. American Red Cross, Washington, D. C.
 Lewis, Mrs. J. M., Cleveland, Ohio.
 Littlefield, J. D., Instructor, Cleveland, Ohio.
 Littlefield, Mrs. J. D., Cleveland, Ohio.
 Laffer, Walter B., Cleveland, Ohio.
 McMaster, Samuel E., M. D., 504 Ohio Bldg., Akron, Ohio.
 Means, Margaret K., Associated Charities, Cleveland, Ohio.
 Medington, Mildred F., Assoc. Charities Visitor, Cleveland, Ohio.
 Mateer, Florence, Ph. D., Psycho-Clinician Bureau of Juvenile Research,
 Columbus, Ohio.
 Morgan, D. H., Akron, Ohio.
 McMaster, W. H., Pres. Mt. Union College, Alliance, Ohio.
 Mittendorf, Louise M., Superintendent Ohio Reformatory for Women,
 Marysville, Ohio.
 McCarty, Chas. W., 134 W. 34th St., New York City.
 Mignot, Marie, Cuyahoga Falls, Ohio.
 Murdoch, Dr. Katharine, New York.
 Murdoch, Mrs. J. M., Polk, Pa.
 Nelson, Laura H., Supervisor A. R. C., Cleveland, Ohio.
 Newcomer, H. S., M. D., Scientific Director Penna. Hospital, Philadel-
 phia, Pa.
 North, Mrs. E. A., Cincinnati, Ohio.
 Nash, A. C., M. D., Cleveland, Ohio.
 Ostrander, Mrs. Herman, Kalamazoo, Mich.
 Pollock, Horatio M., Statistician N. Y. State Hospital Commission,
 Albany, N. Y.
 Pollock, Mrs. H. M., Albany, N. Y.
 Perry, Mrs. Sara S., Kalamazoo, Mich.
 Perry, Stephen W., Asst. Physician Kalamazoo State Hospital, Kala-
 mazoo, Mich.
 Potter, Mrs. F. C., Kalamazoo, Mich.
 Richmond, H. W., M. D., Dorcas Invalids Home, Cleveland, Ohio.
 Rudisell, James, Member Board of Trustees Penna. State Lunatic Hospi-
 tal, Harrisburg, Pa.
 Robinson, Ruth, London, Ont.
 Rapp, Walter, Pres. Medfield State Board Trustees, Brockton, Mass.
 Reeve, George H., Neuro-Psychiatrist A. R. C., Cleveland, Ohio.

- Ross, Mrs. John R., Dannemora, N. Y.
Reynolds, Marion S., Asst. Physician Columbus State Hospital, Columbus, Ohio.
Robinson, Emily, Pathologist Salem Hospital, Salem, Ohio.
Stebbins, Inez F., Parole Agent Rome State School, Rome, N. Y.
Severance, C. J., M. D., Manager Rome State School, Mannsville, N. Y.
Sylvester, R. H., Director Des Moines Health Center, City Hall, Des Moines, Iowa.
Starkey, Frank R., Clinical Prof. Neurology.
Stevens, Elmer A., Mass. Com. on Mental Diseases, West Somerville, Mass.
Spear, Marion R., Director Occupational Therapy Kalamazoo State Hospital, Kalamazoo, Mich.
Slagle, Eleanor C., Gen. Supt. Occupational Therapy Dept. of Public Welfare, Chicago State Hospital, Dunning, Ill.
Springer, J. Gordon, M. D., Superintendent Southwestern Insane Asylum, San Antonio, Tex.
Staples, Katharine C., Occupational Director Cook County Hospital, Evanston, Ill.
Shanklin, Mary E., Chief Therapist Watertown State Hospital, East Moline, Ill.
Sloan, George A., M. D., Erie County Hospital, Buffalo, N. Y.
Stanley, E. F., M. D., Superintendent Vermont State Hospital, Waterbury, Vt.
Stanley, Eva B., Waterbury, Vt.
Simms, Marion, Asst. Supervisor State Hospital, Cleveland, Ohio.
Sibley, Anna E., Special Teacher, Toledo, Ohio.
Tirnan, John B., Member Commission on Mental Diseases, Salem, Mass.
Tirnan, Mrs. John B., Salem, Mass.
Wagenhals, F. C., M. D., Med. Dept. Ohio State University, Columbus, Ohio.
West, K. S., M. D., Clinical Psychiatrist, 636 Rose Building, Cleveland, Ohio.
Williams, Mrs. G. H., Cleveland, Ohio.
Woodell, Edith E., M. D., Sr. Asst. Physician Mass. School for Feeble-Minded, Waverly, Mass.
Yule, Anna H., Cleveland, Ohio.
Zimmerly, Helen R., Fair Oaks Villa, Cuyahoga Falls, Ohio.
Thomas, Mrs. A. C., Foxboro, Mass.
Thomas, Mrs. John N., Pineville, La.
Tierney, John S., M. D., 1002 Rose Bldg., Cleveland, Ohio.
Tompkins, Anna L., Chief Occupational Therapist Chicago State Hospital, Dunning, Ill.
Wiseman, Katherine F., M. D., State Hospital, Middletown, Conn.

THE PRESIDENT.—Will the audience please stand while the Secretary reads the names of the deceased members for the year, after which there will be a moment of silent prayer.

The audience arose and the Secretary read the following names:

James Buckley, D. D., LL. D., Paul L. Cort, M. D., Edward Cowles, M. D., (President 1895), Marcel J. DeMahy, M. D., Britton D. Evans, M. D., Amos J. Givens, M. D., L. S. Hinckley, M. D., August Hoch, M. D., Leonard C. Mead, M. D., James T. Searcy, M. D. (President 1913), Edwin E. Smith, M. D., Elmer Ernest Southard, M. D. (President 1919), Henry M. Bannister, M. D., W. P. Crumbacker, M. D., H. L. Orth, M. D., John C. Mitchell, M. D., Dwight S. Spellman, M. D.

THE PRESIDENT.—I will ask the Vice-President to take the chair.

DR. COPP (presiding).—The address by the President is now in order.

President Eyman read his address, which was received with applause.

DR. BROWN.—We have greatly enjoyed the President's address. I have a premonition that those people to whom Dr. Brush so feelingly alluded this morning, namely, the compositors and proof-readers, will also be delighted. I congratulate you Dr. Brush, and I wish to move a vote of thanks to the President.

DR. BRUSH.—I am very glad to second that motion, and in seconding it would say I think we should send a vote of thanks to that young lady for thinking that ship was a ship until it reached land.

DR. COPP (presiding).—We all appreciate the very interesting and illuminating manner in which the President has given us his address, and every one will feel like responding cordially to this vote of thanks to the President. Will you express this feeling by rising?

Motion unanimously carried by a rising vote.

DR. COPP (presiding).—This closes the formal exercises of the morning. We wish to call your attention to the fact that at the end of this corridor on this floor, there is a very interesting exhibit of the occupation of patients of the different hospitals, and it is suggested that you find your way there early and go often. In closing this meeting you are reminded that the afternoon session begins promptly at 2.30, and we shall expect to see you all here.

The meeting is adjourned.

AFTERNOON SESSION.

THE PRESIDENT.—Will the Association please come to order. The report of the Committee on Occupational Therapy will be deferred until later. At this time I will appoint a committee to award certificates of merit. The committee will be made up as follows: O. O. Fordyce, M. D., Ohio; Richard H. Hutchings, M. D., New York; Edith R. Spaulding, M. D., New York; Mrs. Owen Copp, Pennsylvania; Mrs. Edward N. Brush, Maryland.

The first paper on the program for the afternoon is "Medical and Administrative Management of Ohio's Institutions," by Emerson A. North, M. D., Cincinnati, Ohio. The discussion of this paper will be opened by Dr. Charles H. Clark, after which there will be general discussion.

Dr. North read his paper, which was discussed by Drs. Charles H. Clark, Albert Anderson, Kilbourne, Hamilton and North in closing.

THE PRESIDENT.—The next paper on the program is by Dr. Wm. H. Pritchard, of Columbus, O., entitled "The Responsibility of the Public in Relation to State Medical Institutions." This paper will be open for general discussion at its conclusion.

Dr. Pritchard read his paper, which was discussed by Drs. Copp, Evans and Pritchard in closing.

THE PRESIDENT.—The next paper on the program—that of Dr. McCarthy—will be postponed until Thursday.

We will now listen to a paper on "The Organization of the Criminologist's Division in Illinois," by Dr. Herman M. Adler, Chicago, Ill.

At the conclusion of Dr. Adler's paper, the President announced that Dr. Singer would open the discussion.

DR. COPP (presiding).—Before calling for the next paper, the Secretary has an announcement to make.

THE SECRETARY.—A meeting of the Council is desired at the close of this session, to pass upon applications for membership. I would also announce that Dr. Baber desires to meet all the physicians from Ohio immediately after this session adjourns.

DR. COPP (presiding).—The next paper on the program is by Dr. Henry H. Goddard, Columbus, Ohio, on "Juvenile Psychopaths." Dr. Fell, who was to open the discussion is not present, so this paper will be open for general discussion.

Dr. Goddard's paper was discussed by Dr. J. M. Murdock.

The Vice-President announced that as there was no further discussion of this paper, the meeting was adjourned until evening.

EVENING SESSION.

THE PRESIDENT.—The first number on our program this evening is "The New Age and the New Red Cross," by Prof. George R. Laird, Special Representative of the Speaker's Bureau of the American Red Cross, Washington, D. C.

At the conclusion of Prof. Laird's address the President announced that the address was not open for discussion, but that

the speaker would be pleased to answer any questions the members desired to ask.

THE PRESIDENT.—The Secretary has an announcement to make.

The Secretary announced that the Committee of Arrangements desired all ladies intending to take the automobile trip tomorrow to be at the side door promptly at two o'clock in the afternoon.

THE PRESIDENT.—The next paper on the program is by Dr. C. B. Burr, of Flint, Mich., and is entitled "Insanité, Legalité, Insecurité." The discussion of this paper will be opened by Dr. Richard Dewey.

Dr. Burr's paper was discussed by Dr. Dewey and Dr. Burr, in closing.

DR. COPP (presiding).—The next two papers on the program being somewhat similar, perhaps we had better combine the discussion of these papers.

The following papers were read:

"Out-patient or Dispensary Clinics for Mental Cases," by E. Stanley Abbot, M. D., Philadelphia; "An Out-Patient Clinic in Connection With a State Institution for the Feeble-Minded," by Walter E. Fernald, M. D., Waverley, Mass.

DR. COPP (presiding).—It is an inspiration to see and hear a man like Dr. Fernald and another like Dr. Abbot talk on this very important subject. We can hardly realize all its importance and the wide scope which it is going to have in the future. I wish we were just starting in the morning and could continue all day with it. Dr. Green will open the discussion.

The above papers were discussed by Drs. Green, Murdoch, Copp, Burr, Abbot and Fernald in closing.

THE PRESIDENT.—The meeting is adjourned until ten o'clock tomorrow morning.

WEDNESDAY, JUNE 2, 1920.

MORNING SESSION.

The meeting was called to order by the President.

THE PRESIDENT.—I will ask the Secretary to read the report of the Council.

REPORT OF COUNCIL JUNE 2, 1920.

The Council recommends the transfer from Associate to active membership James J. Gable, M. D., Norman, Okla.

The Council also recommends the election of the following physicians to associate membership in the Association:

Henry E. Austin, M.D., Middletown, Conn.; Angela Baber, M.D., Northampton, Mass.; Arthur N. Ball, M.D., Northampton, Mass.; Thomas P. Brennan, M.D., Iowa City, Iowa; R. E. Bushong, M.D., Toledo, O.; Henry M. Chandler, M.D., Middletown, Conn.; Alvin H. Cranz, M.D., Middletown, Conn.; Ethel Davis, M.D., Chicago, Ill.; John Favill, M.D., Chicago, Ill.; Paul R. Felt, M.D., Middletown, Conn.; Walter J. Hammond, M.D., Bangor, Me.; David Levy, M.D., Chicago, Ill.; Stephen K. Perry, M.D., Kalamazoo, Mich.; David C. Phillips, M.D., Joliet, Ill.; George H. Reeve, M.D., Cleveland, O.; Marion S. Reynolds, M.D., Columbus, O.; Harold R. Robert, M.D., Dannemora, N. Y.; Charles C. Rowley, M.D., Pontiac, Ill.; Lewis J. Smith, M.D., Beacon, N. Y.; W. H. Spiers, M.D., Chattahoochee, Fla.; Edward W. Whitney, M.D., Northampton, Mass.; Elmer V. Eyman, M.D., Philadelphia, Pa.

The Council has received and considered the following applications for active membership. In accordance with the constitution, final action will be deferred until next year:

Albert Evans, M.D., Boston, Mass.; George A. Sloan, M.D., Buffalo, N. Y., and Eugene A. Stanley, M.D., Waterbury, Vt.

Respectfully Submitted,

H. W. MITCHELL, *Secretary.*

THE PRESIDENT.—What will you do with this report?

Motion made and carried that the report of the Council be accepted and adopted, and that the applications for associate membership lie on the table until tomorrow morning.

THE PRESIDENT.—We will now take action on the names presented yesterday morning. Is it the wish of the Association that the Secretary re-read these names? If not will some one make a motion that the Secretary be instructed to cast the ballot for their election.

DR. ABBOT.—I move that the Secretary be authorized to cast the ballot as printed.

The President asked for the vote, which was unanimous, and the Secretary announced that the ballot had been cast.

THE PRESIDENT.—The list of candidates for active membership was read a year ago and we are now ready for action on these names. The Secretary will read the names of these candidates which the Council has considered very carefully.

The Secretary read the list as submitted a year ago.

THE PRESIDENT.—Unless some one has objection, a motion is in order in regard to the election of these men.

DR. BURR.—I move that the Secretary be instructed to cast the ballot for the election of the names as read, to active membership in this Association.

This motion was duly seconded and carried, and the Secretary announced that the ballot had been cast.

THE PRESIDENT.—We will now proceed to the transfer of associate members to the active list, as recommended by the Council yesterday.

DR. BURR.—I move that the Secretary be authorized to cast the ballot for the transfer of the associate members to active, as presented yesterday.

Motion seconded and carried.

The Secretary stated that the ballot had been cast as directed.

(The list of these candidates for election and transfer will be found in the report of the Council for June 1, 1920.)

THE PRESIDENT.—We will listen to the report of the Nominating Committee, Dr. Wagner, Chairman.

DR. WAGNER.—Your committee, in pursuance of a time honored custom, is pleased to place before you for President, our Vice-President, Owen Copp, M. D., of Pennsylvania.

In casting about for Vice-President, there appeared to be but one mind, and the committee places the nomination of Sanger Brown, M. D., of Illinois, before the Association.

For Secretary-Treasurer, Dr. H. W. Mitchell, Warren, Pa.

For Councillor for two years, in place of Dr. E. E. Southard, (deceased), Dr. Frederick H. Packard, Waverley, Mass.

For Councilor for one year, in place of Dr. B. D. Evans (deceased), Dr. Wm. W. Richardson, Mercer, Pa.

For Councilors for three years: Dr. H. C. Eyman, Massillon, O.; Dr. Isham G. Harris, Brooklyn, N. Y.; Dr. Anne Burnett, Antigo, Wis.; Dr. Alfred T. Hobbs, Guelph, Ont., Canada.

For Auditor for three years: Dr. Walter G. Ryon, Poughkeepsie, N. Y.

(Signed) CHARLES G. WAGNER,

C. B. BURR,

CHARLES H. CLARK,

Nominating Committee.

THE PRESIDENT.—What will you do with this report?

DR. RICHARD DEWEY.—I move the adoption of the report of the Nominating Committee, and that the Secretary be authorized to cast the ballot of the Association for the election of the persons named in the report.

Motion seconded and unanimously carried. Ballot was cast.

THE PRESIDENT.—We will hear the report of the Auditors.

DR. WM. L. RUSSELL.—The Auditors have examined the books of the Treasurer and of the editors of the AMERICAN JOURNAL OF INSANITY and find them perfectly correct.

(Signed) WM. L. RUSSELL, *Auditor.*

THE PRESIDENT.—Has the Committee on Statistics a report? If not, it will be postponed until to-morrow morning.

I will appoint as members of the Committee on Resolutions: Dr. Edward N. Brush, Maryland, Chairman; Dr. Richard Dewey, Wisconsin; Dr. Chas. H. Bancroft, New Hampshire.

THE PRESIDENT.—The subject this morning will be along the line of Mental Hygiene; the first paper will be "The Practical Aims of the National Committee for Mental Hygiene," by Thomas W. Salmon, M. D., New York City.

Inasmuch as these papers now to be read are of a similar nature we will postpone the discussion until the last paper.

At the conclusion of Dr. Salmon's paper, the following papers were read:

"The Field of a State Society for Mental Hygiene," by E. Stanley Abbot, M. D., Philadelphia, Pa.; "Ten Years' Work of the Illinois Society for Mental Hygiene," by Ralph P. Truitt, M. D., Chicago, Ill.; "What an Adequate Program in Mental Hygiene Involves for a State Hospital System," by George M. Kline, M. D., Boston, Mass.

THE PRESIDENT.—We will postpone the reading of Mr. Elwood's paper until afternoon, and prior to adjournment I shall re-open the question of "Unfinished Business" in favor of Dr. May, who has a motion to make.

DR. JAMES V. MAY.—It was largely at my suggestion last year that the question of revision of the constitution and changing the name of the Association was taken up at the session in Philadelphia. It was at that time generally expected that the Committee on Revision of the Constitution would be able to present a report at that meeting. This, however, was not practicable and it is quite possible that the committee will not be able to make a complete report at the session this year. I feel that it would be unwise to act on the amendment relating to the change in name of the Association until the Committee on Revision is in a position to make its final report. I would like to make a motion, therefore, that action on that amendment be deferred until the committee has made its final report.

DR. RICHARD DEWEY.—I second that motion.

Dr. May's motion was unanimously carried.

THE PRESIDENT.—Dr. Orton has an announcement to make.

Dr. Orton announced that places at the Round Table Conference on Thursday evening must be reserved in advance, by filling in cards at the registration desk, before the end of the afternoon

session to-day; that separate cards must be made out for each individual desiring to attend.

THE PRESIDENT.—Discussion of the papers just read is now in order.

Papers by Drs. Salmon, Abbot, Truitt and Kline, were discussed by Drs. Blumer, Kilbourne, Copp, Brush, Anderson, Mitchell, Williams, Ostrander, and Salmon in closing.

THE PRESIDENT.—I would call attention to the registration desk, which is directly across the hall, and ask that everybody who has not already done so, will register their names there.

Adjournment.

AFTERNOON SESSION.

The Association was called to order at 2.30 p. m. by the President.

THE PRESIDENT.—The first thing on this afternoon's program will be the report of the Committee on Nursing, Dr. Guthrie, Chairman.

REPORT OF COMMITTEE ON NURSING.

The following resolution was introduced by Dr. Gorst and adopted by the American Medico-Psychological Association at the meeting held in Chicago, 1918:

"Resolved, That a committee be appointed by this Association whose duty it shall be to investigate the methods of nursing and attendant care in both acute and chronic cases of the insane practiced in the United States and Canada, and to make its report, with recommendations at the next annual meeting."

Owing to abnormal conditions throughout the United States and Canada incident to the world war, no report or recommendation was made at the Philadelphia meeting, as required by the above resolution.

Your committee has found that conditions have not yet returned to normal, as compared with the period before the war. We have undertaken, however, to report upon the situation as we find it at present and to offer recommendations pertinent thereto.

In order to get an expression from superintendents in various parts of the United States and Canada, a questionnaire was sent out on January 8 of this year. The list was prepared at random on a basis of 33¼ per cent of the membership, with the view of securing representative expression.

It is very gratifying to your committee to be able to state that practically all questionnaires were promptly filled out and returned, and the following information was obtained from same:

Ninety-nine per cent of the superintendents had difficulty in securing acceptable nurses.

The shortage of nurses was attributed to war conditions, higher rate of wages in other employments, long hours of disagreeable work in insti-

tutions, falling off in immigration and the transfer of many women to work usually done by men.

Less than 50 per cent of the institutions had training schools and less than 10 per cent of these were affiliated with a general hospital.

One hundred per cent of the superintendents who had training schools stated that the efficiency of their staff had been increased. Seventy per cent of those who had training schools stated that such training was optional. The course of training covered between two and three years.

Wages for pupil nurses and graduates show a wide discrepancy between various institutions, the figures being \$10 to \$12 for pupil nurses and from \$60 to \$110 for graduate nurses.

The answers indicated that as a usual thing the graduate nurses went into general hospitals, became private nurses, or entered upon matrimonial adventures, very few remaining in the parent institutions.

As to what method should be suggested to make more permanent the nursing staff included, generally, better working conditions, higher wages and shorter hours.

As to whether there should be an interchange of work of undergraduates with nurses of a general hospital staff, the answers indicated a division of opinion. Some answered in the affirmative, while others were of the opinion that the nursing forces of the hospitals for the insane were in danger of disorganization by reason of association with undergraduates from general hospitals.

Ninety-nine per cent of the replies were in favor of teaching elementary nursing, first aid, and dietetics in public schools. One negative answer condemned this practice as being a "fad."

The hours recommended for a day's work ranged from 8 to 14, but with a preponderance favoring a 12-hour day.

The wage rate varied widely in different sections traversed by the questionnaire. In the United States the lowest wages are found in the South. The United States Government rate at Washington, D. C., was as follows:

"Pupil nurses and attendants, \$40 to \$50 per month. Graduate nurses, \$55 to \$65 per month. Charge nurses, \$52.50 to \$67.50 per month. Assistant supervisors, \$55 to \$75 per month. Supervisors, \$60 to \$85 per month. Increase in all grades from minimum to maximum at rate of \$2.50 for every six month of continuous service. In addition there is a bonus in each case of \$20 per month at the present time granted by Congress to all those employees above listed."

The attitude of the superintendents in answering the questionnaires relative to employees of other institutions discharged or otherwise, for the most part indicated proper regard for an ethical attitude, but a few superintendents admitted that owing to a scarcity of nurses they were compelled to accept inferior material.

The suggestion of an eight-hour shift for employees in hospitals for the insane provoked, as might have been expected, a marked divergence of opinion. A few maintained that shorter hours would result in better

service, nevertheless, the predominance of opinion upheld the twelve-hour shift. Superintendents pointed out freely the enormous expense that would attend the change from twelve to eight hours, which would mean the addition of one-third more employees to many institutions in the country. This expense enlarged by the necessity for providing additional housing facilities and board for the third shift of employees, would seem to preclude the change as being impractical upon the present basis of administration.

Many experienced superintendents argued that with three shifts or the eight-hour turn, there would be constantly 66⅔ per cent of the total number of employees idle around the institutions—a situation that would tend to stir up mischief and promote disorganization. Furthermore, there was expressed more or less generally the belief that with three shifts the responsibilities of the employees toward the patient would be so divided that a loss of personal interest would ensue and the welfare of the patients would be jeopardized.

It should be borne in mind that there is a distinctive difference between being "on duty" twelve hours a day and "working" twelve hours a day. It is one thing for a bricklayer, a carpenter or a hodcarrier to work eight hours per day and quite another matter for a nurse or hospital attendant to be on duty twelve hours. It is doubtful whether the nurse or attendant during the twelve-hour turn, really has six hours of actual work with about one hour and a half a day for meals, and the time further lightened by that consumed in going backward and forward on visits to their rooms, and their regular holiday periods which are granted without any deduction of pay.

It has been suggested that after making the proper deduction for time off duty, it will be found that the actual time on duty amounts to little more than eight hours per day and that about six hours of this time is put in in light, but at times, distasteful work.

Of all the superintendents interrogated only one was found to be in favor of the unionization of hospital employees and their affiliation with the American Federation of Labor. Almost the whole of the replies from superintendents vigorously opposed and condemned this proposal and offered the opinion that the unionization of hospital employees cannot be too strongly resisted. The answers to the questions also pointed out the following:

"The success of this movement would be detrimental alike to the employee, the patient and the state at large. The natural result of unionization would be to prostitute hospital service to a common level—far below the average maintained to-day. The first-class attendant would be robbed of the incentive of seeking enlarged reward by reason of superior diligence and capability. He would, on the contrary, be compelled to rank with the mediocre and inefficient whose rewards would be equal to his own. The greatest progressive principle in human life in this free republic would be strangled, and a bar sinister set up to progress. Loyalty to their employer (the state) would be transferred to loyalty to

the union, and under such a condition a lowering of standards and a grievous demoralization would undoubtedly ensue."

A superintendent of wide experience and broad conception stated: "I consider this thing unwise and improper from the standpoint of the laboring people themselves. The majority of the patients in public hospitals for the insane come from the poorer classes. The rich resort to the private sanitarium, or to private nursing. It certainly would be unfair to the unfortunates in our hospitals to bring about a condition wherein the superintendent, a man skilled in his work, would be forced into subserviency to a union whose members are wholly unskilled in medical science and general administration. The change of aspect of these institutions from the purely humanitarian to the commercial, as unionization would bring about, conjures possibilities against which every superintendent and every layman in the broad field of humanity should offer the stoutest resistance."

"If bricklayers engaged in putting up a building should go on a strike, there would be no suffering on the part of the inanimate clay composite in the brick, but if the nurses and attendants in a hospital, acting at the call of their union head, should go on strike, deserting their patients, the consequences may be more easily imagined than described. The thing is intolerable."

RECOMMENDATIONS.

The data received from the questionnaire prompts the following recommendations:

1. The housing accommodations for hospital employees should be distinctly apart from the wards in which they are employed.
2. A material increase in the rate of wages will go far towards the solution of present difficulties.
3. Increased immigration from the English speaking countries should be encouraged.

In addition the committee feels it is an opportune time to properly recognize the importance of the whole subject of nursing in general, and especially as it relates to the care of the insane. The experience of the past several years indicates that the nursing problem involves more than its mere consideration as a vocation or profession used only to meet the needs of the individual who comes to our attention as physically or mentally ill. We believe it should be looked upon as of national importance and regarded as an essential defense, to meet the invasion of epidemics, the requirements of war and the general conservation of our national life. We suggest that its importance should be recognized and the subject taught in the common schools and that related courses should be given in the secondary and high schools. This will attract many young women to take up nursing as a profession who would otherwise drift into other occupations, and these young women so taught, whether attaining the goal of professional nurses or not, would become better housewives and better mothers for this experience. Not only this, but the information

and experience thus acquired might easily prove invaluable in case of epidemic or other calamity affecting the community.

We believe that mentally ill patients should have nursing care, and that a training school for nurses should be an essential of a hospital's organization. Where it is not possible to obtain a sufficient number of pupil and graduate nurses to care for all the patients, at least the acute cases and the physically ill could get this care, arranging for the usual attendance to do the work of a more custodial nature.

We further suggest that this organization should not only go on record as strongly recommending the establishing of a training school for nurses in every hospital, but in addition should prescribe and lay out a course for training schools. This would establish a standard which could assist the individual hospital and at the same time improve and raise the level of care of the insane patient throughout the whole country.

The elimination of the itinerant attendant is a difficult matter, especially in times such as those through which we have been passing. When not contrary to law, we suggest that hospital superintendents living in states grouped regionally, send out lists to other superintendents outside the regional group, giving the name of all attendants discharged, or those resigning without proper notice. By this method much could be done toward eliminating the undesirables.

We feel that we should not close this report without an expression of our high regard and gratitude for the faithful employees who have shown their devotion to duty during the past two or three years of stress in institutional management.

Respectfully submitted,

(Signed) L. V. GUTHRIE, *Chairman*,
E. H. COHOON,
R. H. HUTCHINGS,
W. H. PRITCHARD.

THE PRESIDENT.—What will you do with this report?

DR. BLUMER.—I move that the report of the Committee on Nursing be received, and that the committee be continued. It is very easy to make a motion of that kind. Whenever I hear a report involving a great deal of work I feel that we owe the gentlemen who have given so much of their time, something more than a motion to receive the report and to continue the committee. We owe Dr. Guthrie, I am sure, a great debt of thanks for the work he has done.

I would like to say something with reference to the difficulty of getting an adequate amount of service during the summer. I think I may say that at Butler Hospital, where it has been very difficult to get all the nurses we need, I recently took recourse to the expedient of writing to the superintendent of public schools, who in turn interviewed all the principals of the schools in Providence, offering employment to teachers at from \$35 to \$45 per month, those teachers to be regarded as ward attendants, or something of the kind, and to get, in addition to their salaries, intensive

training during that period. The superintendent of schools in Providence told me just before I left home that he thought it likely there would be quite a number of responses; that teachers would be glad to avail themselves of the extra money during the summer, while at the same time promoting their usefulness as citizens.

DR. BRUSH.—I would second that motion.

Dr. Blumer's motion was unanimously carried.

The following papers were then read:

"The State Hospital's Part in the Mental Hygiene Movement," by Mr. Everett S. Elwood, Albany, N. Y. (by invitation); "Mental Problems in Delinquent School Children," by Sanger Brown, II, M. D., New York, N. Y. Discussed by Drs. Tom A. Williams and Brush.

DR. COFF (presiding).—The reader of the next paper is Dr. Cornell. The discussion of his paper will be postponed until the next paper is read.

The following papers were read:

"New Fields for Mental Hygiene," by W. B. Cornell, M. D., Albany, N. Y.; "An Extension Course in Psychiatric Social Service," by Harold I. Gosline, M. D., Howard, R. I.

Drs. Cornell and Gosline's papers were discussed by Drs. Abbot, Blumer, James K. Hall, and Gosline in closing.

Adjournment.

EVENING SESSION.

President Eyman called the Association to order at 8.30 p. m.

THE PRESIDENT.—*Ladies and gentlemen:* It gives me very great pleasure to introduce to you to-night a gentleman whom it has been my privilege to know for several years. You did not come here to-night to hear me make a speech, therefore the only word of introduction I will say to you is that we are going to be addressed this evening by a man whose words I know you will enjoy, and I have great pleasure in introducing Dr. W. H. McMasters, President of Mt. Union College, Alliance, Ohio.

Dr. McMasters delivered the Annual Address, which was received with much applause.

DR. BRUSH.—*Mr. President:* I tried to persuade a gentleman near me that it was his duty to get on his feet and say a word. I rise to offer, on behalf of the Association, a motion that the thanks of the Association be extended to the eloquent speaker of the evening, for this most enlightening and uplifting address. I am glad the speaker has discovered that when the doctor takes a vacation the patients get well. Dr. Burr and myself will find a great deal of satisfaction in this in taking our long vacation.

I have listened to many addresses before this Association—many of them from manuscript—and I have not listened to any with greater pleasure than the one this evening; indeed, I am like the person sitting near me who said “I could listen for an hour longer.” I move, therefore, that we give Dr. McMasters, President of Mt. Union College, a rising vote of thanks.

Dr. Brush’s motion was duly seconded and unanimously carried by a rising vote.

Adjournment.

After adjournment the President’s Reception was held, followed by dancing.

THURSDAY, JUNE 3, 1920.

MORNING SESSION.

THE PRESIDENT.—The Association will please come to order.

The first business this morning is the report of the Council by the Secretary.

REPORT OF THE COUNCIL, JUNE 3, 1920.

The Council recommends the election of the following physicians to associate membership:

Harold W. Brann, M.D., Cleveland, O.; Charles H. Creed, M.D., Columbus, O.; Charles Englander, M.D., Cedar Grove, N. J.; Paul J. Everhardt, M.D., Towson, Md.; Ola A. Kibler, M.D., Chicago, Ill.; Richard S. Moynan, M.D., Cleveland, O.; Frank G. Norbury, M.D., Jacksonville, Ill.; G. Blake Smith, M.D., Godfrey, Ill.; John M. Thompson, M.D., Cedar Grove, N. J.

The Council has received the applications of the following physicians for active membership. In accordance with the constitution, final consideration will be deferred until next year:

Samuel Dodds, M.D., Logansport, Ind.; C. Banks McNairy, M.D., Kinston, N. C.; Clarence Neymann, M.D., Chicago, Ill.; Alfred B. Olsen, M.D., Worthington, O.; A. S. Pendleton, M.D., Washington, D. C.; H. B. Sanborn, M.D., Providence, R. I.

The Council recommends that the invitation of the City of Boston, extended through Dr. Kline, to meet in that city next year, be accepted, and that the annual meeting of the Association be held in Boston, Mass., in 1921, the date to be determined later by the President and the Secretary.

The proposed Constitution and By-Laws was read and explained by Dr. Copp, Chairman of the Committee on Revision of the Constitution. After general discussion, it was moved by Dr. Brush and seconded by Dr. Work, that the report of the committee be accepted with the approval of the Council.

Respectfully submitted,

H. W. MITCHELL, *Secretary*.

DR. BURR.—I move that the report of the Council be accepted and adopted.

Motion seconded and carried.

THE SECRETARY.—The candidates for associate membership reported at an earlier session are now eligible for election; if it is the pleasure of the Association I will read the names.

(The list will be found in the report of the Council of June 2, 1920.)

THE PRESIDENT.—A motion is in order in regard to the election of these gentlemen.

DR. BURR.—I move that the Secretary be authorized to cast a ballot for the election of the candidates as read.

Motion seconded and carried.

The Secretary announced that the ballot had been cast.

THE PRESIDENT.—We will now listen to the report of the Committee on Revision of the Constitution, Dr. Copp, Chairman.

REPORT OF COMMITTEE ON REVISION OF CONSTITUTION.

The Committee on Revision of the Constitution and By-Laws of the Association respectfully submits the following report with recommendations:

First.—That the name of the Association be changed to "American Psychiatric Association."

Second.—That the retiring President be nominated for Councilor for three years and other ex-presidents be ex-officio Councilors without power to vote.

Third.—That the term "Active Member" be changed to "Fellow," and the term "Associate Member" to "Member."

Fourth.—That such physicians other than assistant physicians in institutions for the insane be eligible for membership as may be deemed suitable by the Council.

Fifth.—That any candidate for admission to the Association hereafter as a "Fellow" whose name has been properly presented to the Council at its first session Monday evening and to the Association at its first business session on Tuesday, may, on unanimous recommendation of the Council, if no objection be made, be elected the following Wednesday or Thursday.

The changes necessary to carry out these recommendations and certain other changes in phraseology which do not modify meaning, but express implied function or present practice, are embodied in the following draft of the revision of the Constitution and By-Laws, as proposed by the Committee.

CONSTITUTION.

Article I.

This organization shall be known as the American Psychiatric Association and is continuous with the organization known from 1844 to 1892 as the Association of Medical Superintendents of American Institutions for the Insane and from 1892 to 1921 as the American Medico-Psychological Association.

Article II.

The object of this Association shall be the study of all subjects pertaining to mental disease and defect, including the care, treatment and promotion of the best interests of the insane, epileptic, feeble-minded and allied classes.

Article III.

There shall be five classes of members: (1) Fellows, who shall be physicians, resident in the United States or British America, especially interested in subjects pertaining to mental disease and defect: (2) Members; (3) Life members; (4) Honorary members; (5) Corresponding members.

Article IV.

The officers of the Association shall be a President, Vice-President, Secretary—who shall also be the Treasurer—three Auditors, and twelve Fellows or life members of the Association to be called Councilors; these officers together shall constitute a body which shall be known as the Council. The retiring President shall be nominated for Councilor for three years and other ex-presidents be ex-officio Councilors without power to vote.

Article V.

The Fellows of the Association shall include the active members in the official list published in 1921 of members of the American Medico-Psychological Association.

Physicians who by their professional work or published writings have shown a special interest in the care and welfare of the insane and allied classes are eligible to Fellowship.

The Class, Members, shall include the names of Associate members published in the above mentioned list.

Those eligible for membership in this class are regularly appointed assistant physicians of institutions for the insane that are regarded to be properly such by the Council and such other physicians as are deemed suitable for membership by the Council. After three years a Member may become a Fellow by making application in writing to the Council and upon its approval being elected in the manner hereafter prescribed.

Life members shall be such Fellows as shall have been Fellows or Members of the Association for a period of thirty (30) consecutive years.

Among Honorary members shall be included the names of such published in the above mentioned list. Physicians and others who have dis-

tinguished themselves by attainments in branches of science pertaining to mental disease and defect, or who have rendered signal service in philanthropic efforts to promote the interests of persons subject thereto, shall be eligible for Honorary membership.

Corresponding members shall be those hereafter elected as such.

Physicians not residents of the United States or British America, who are actively engaged in the treatment of mental disease or defect may be elected Corresponding members.

The above lists shall be corrected by the Council as may be necessary to carry out the intention of the Constitution as to continuance of existing membership.

Every candidate for admission to the Association hereafter as a Fellow shall be proposed to the Council, in writing, in an application addressed to the President, at any annual meeting preceding the one at which the election is held; provided that any such candidate, whose name has been properly presented to the Council at its first session Monday evening and to the Association at its first business session on Tuesday, may on unanimous recommendation of the Council, if no objection be made, be elected the following Wednesday or Thursday.

Members, Honorary and Corresponding Members, may be elected after approval by the Council of applications, which shall be made in writing, and addressed to the President, at least two months prior to the meeting of the Association.

Every application of whatever class must include a statement of the candidate's name and residence, professional qualifications, any appointments then or formerly held, and certification that he is a fit and proper person for Fellowship, or Membership.

In the case of a candidate for Fellowship or Membership, the application shall be signed by three Fellows or life members of the Association; and the proposal for an Honorary member or Corresponding member by six.

The names of all candidates approved by a majority vote of members of the Council present at its annual meeting shall be presented on a written or printed ballot to the Association at its concurrent annual meeting, at least one session previous to that at which the election is made, which shall be by ballot at a regular session and require a majority vote of the members present and voting.

Article VI.

Fellows and Life members only shall be entitled to vote at any meeting or be eligible to office in the Association. Life members, Honorary members and corresponding members shall be exempt from the payment of annual dues to the Association.

Article VII.

Any member of the Association may withdraw from it on signifying his desire to do so in writing to the Secretary: Provided, That he shall have paid all dues to the Association. Any member who shall fail for three

successive years to pay dues after special notice by the Treasurer shall be regarded as having resigned membership, unless such dues are remitted by the Council for good and sufficient reasons.

The name of any member declared unfit for membership by two-thirds vote of the members of the Council present at an annual meeting of that body shall be presented by the Council to the Association from which he shall be dismissed if it be so voted by a number not less than two-thirds of those present at the annual meeting, registered and voting.

Article VIII.

The Officers and Councilors shall be elected at each annual meeting. They shall be nominated to the Association on the second day of the annual meeting in the order of business of the first session of that day, by a committee appointed for that purpose by the President; and the election shall take place immediately. The election shall be made as the meeting may determine, and the person who shall have received the highest number of votes shall be declared elected to the office for which he has been nominated.

The President, Vice-President, Secretary-Treasurer, and Auditors shall hold office for one year or until the beginning of the term for which their successors are elected. One Auditor shall be elected for one year, one for two years, and one for three years. The Secretary-Treasurer and one Auditor are eligible for re-election. Four Councilors shall be elected each year to hold office three years, or until their successors are elected. The President, Vice-President, one Auditor, and the four retiring Councilors are ineligible for re-election to their respective offices for one year immediately following their retirement. All the officers and Councilors shall enter upon their duties immediately after their election, excepting the President and Vice-President. When any vacancies occur in any of the offices of the Association, they shall be filled by the Council until the next annual meeting.

A quorum of the Council shall be formed by six members; and of the Association by twenty Fellows or Life members.

Article IX.

The President and Vice-President for the year shall enter on their duties at the close of the business of the annual meeting at which they are elected. The President shall prepare an inaugural address to be delivered at the opening session of the next meeting. He shall preside at the annual or special meetings of the Association or Council. In his absence at any time, the Vice-President shall act in his place.

The Secretary-Treasurer shall keep the records of the Association and perform all the duties usually pertaining to that office, and such other duties as may be prescribed for him by the Council; and under the same authority he shall receive and disburse and duly account for all sums of money belonging to the Association. He shall keep accurate accounts and vouchers of all receipts and payments on behalf of the Association, and of all invested funds, with the income and disposition thereof, that

may be placed in his keeping, and shall submit these accounts, with a financial report for the preceding year, to the Council at its annual meeting. Each annual statement shall be examined by the Auditors, who shall prepare and present at each annual meeting of the Association a report showing its financial condition. The Council shall have charge of any funds in the possession of the Association, and these shall be deposited or invested under its direction and control. The Council shall keep a careful record of its proceedings, and make an annual report to the Association of matters of general interest. The Council shall also print annually the proceedings of the meetings of the Association and the reports of the Treasurer and Auditors.

The Council is empowered to manage all the affairs of the Association, subject to the Constitution and By-Laws; to appoint committees from the membership of the Association; to expend money out of its surplus funds for special scientific investigations in matters pertaining to the objects of the Association, and to publish reports of such investigations; and to apply the income of special funds, at its discretion, to the purposes for which they were intended. The Council may also engage in the regular publication of reports, papers, transactions, and other matters, in an annual volume, or in a journal, in such manner and at such times as the Council may determine, with the approval of the Association.

Article X.

Amendments to the Constitution and By-Laws shall be considered at the first session of the second day of any annual meeting, and may be made by a two-thirds vote of all the members present and voting: *Provided*, That notice of proposed amendments has been given in writing at the annual meeting preceding that at which the amendments are submitted for action. It shall be the duty of the Secretary to send to every member at least three months previous to any annual meeting a copy of any proposed amendment.

BY-LAWS.

Article I.

The meetings of the Association shall be held annually. The time and place of each meeting shall be named by the Council, and reported to the Association for its action at the preceding meeting. Each annual meeting shall be called by printed announcements sent to each member at least three months previous to the meeting.

The Council shall hold an annual meeting concurrent with the annual meeting of the Association; and the Council shall hold as many sessions and at such times as the business of the Association may require.

Special meetings of the Council may be called by the order of the Council. The President shall have authority at any time, at his own discretion, to instruct the Secretary to call a special meeting of the Council; and he shall be required to do so upon a request signed by six members of the Council. Such special meetings shall be called by giving at least four weeks' written notice.

Article II.

Each and every Fellow and Member shall pay to the Treasurer such annual dues and assessments as shall be determined by the Council at its annual meeting.

Article III.

The Council shall make arrangements for the meetings of the Association and appoint and define the functions of such auxiliary committees from its own body, and from the membership of the Association as may be necessary.

OWEN COPP, *Chairman*,
C. B. BURR,
CHARLES G. WAGNER.

THE PRESIDENT.—This report will lie on the table, without discussion, for a year. During the year the Secretary will send each member a printed copy of this report.

DR. BRUSH.—The report says: "The members in the printed list of 1920"—should not that read "1921"?

DR. COPP.—I think that would be a proper correction, but that is provided for when the list may be corrected by the Council.

DR. BURR.—As a member of the committee, I would ask Dr. Copp if he will kindly read the provisions for the election of Councilors; as I heard it, it would seem to preclude all Life members from eligibility to the Council.

DR. COPP.—It reads like this: "Fellows and Life members only shall be entitled to vote at any meeting, or be eligible to office in the Association."

THE PRESIDENT.—I will call for the report of the Committee on Pathological Investigation.

DR. ORTON.—Nothing to report.

THE PRESIDENT.—The Committee on Statistics will make its report now.

DR. MAY.—I am making this report for Dr. Barrett, who, unfortunately, is unable to be present.

REPORT OF COMMITTEE ON STATISTICS, AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION, JUNE 3, 1920.

This committee has continued its activities along the same lines as outlined in its report of last year. It has had the cooperation of the Bureau of Statistics of the National Committee for Mental Hygiene in introducing the uniform system of statistics on mental diseases. Practically all of the state hospitals and many of the larger private ones have expressed their approval of the classification of mental diseases, and about 50 per cent have already compiled annual statistics in accordance with the uniform tables.

The first edition of the "Statistical Manual" (3000 copies) is almost exhausted and a second edition is now on the press. Tabular forms have been sent to all cooperating hospitals and over 130,000 record cards have been distributed.

A statistical review of the general operations of state hospitals for the fiscal year 1918 has recently been published by the Bureau of Statistics of the National Committee for Mental Hygiene. This study was based upon data reported by the state hospitals on the first three standard forms. It is planned to make a similar but more comprehensive review for the fiscal year 1919.

The committee held a meeting in New York City, November 11, 1919. At this meeting it was decided to make a few changes in the form of the tables, the most important of which are as follows: To transfer items from Table 3 under the heading "Supplementary Data" to Table 1, General Information, so that Table 3 would include only the movement of patients with mental diseases; and to simplify Table 2, Financial Statement, especially in regard to the items under the heading "Maintenance of Patients."

It was voted to change the term "constitutional psychopathic inferiority" to "psychopathic personality," and to use the term "without psychosis" instead of "not insane."

In view of the many inquiries relative to the race table, it was decided to present a copy of the "Dictionary of Races" to superintendents of cooperating hospitals upon their request.

It was voted that a separate group of statistics be kept for psychopathic hospitals, psychopathic wards and other institutions for temporary care. A subcommittee was appointed for this purpose, consisting of Drs. Barrett, Orton, and Southard. This subcommittee has held one meeting since its appointment, but feels the need of further deliberation before submitting its report.

It was voted that a subcommittee of three outline a system of records for clinics. Drs. Southard, Kirby and Abbot were appointed by the Chairman as members of this subcommittee. This subcommittee has not yet taken action.

It was voted that the Committee on Statistics of this Association co-operate with the Committee on Classification and Uniform Statistics of the American Association for the Study of the Feeble-Minded in order to secure uniform statistics of the feeble-minded.

It was voted that this Committee invite the National Association for the Study of Epilepsy to appoint a committee to confer with it on the subject of uniform statistics.

The committee strongly recommends that central statistical offices be established by the state supervising departments having authority over state hospitals for mental diseases. Such central bureau would receive a statistical card report for each patient received, discharged or deceased, and compile from these cards the annual statistical tables for each hospital for mental diseases in the state. This bureau would also prepare other

tables concerning the general operation of the hospitals. There are several advantages of this method over the system of a separate compilation by each hospital. Briefly, these are: (1) the possibility of employing a trained statistician, (2) uniform method of preparation of statistics, (3) greater accessibility of data, and (4) the cumulation of a larger amount of uniform statistical material from which special studies can be made.

The committee realizes the difficulty involved in substituting a new system of records for one that is established. It, therefore, wishes to express its appreciation of the cooperation that has been shown by the great majority of hospital superintendents in their willingness to follow the Association's classification of mental diseases and to compile annual statistics in accordance with the uniform tabular forms. It strongly urges every member of the Association, who has not already done so, to join in this movement for dependable statistics of mental diseases.

The committee wishes to express its profound sense of loss in the death of Dr. Southard.

Respectfully submitted,

ALBERT M. BARRETT,
E. STANLEY ABBOT,
OWEN COPP,
GEORGE H. KIRBY,
JAMES V. MAY,
SAMUEL S. ORTON,
FRANKWOOD E. WILLIAMS,

Committee on Statistics, American Medico-Psychological Association.

THE PRESIDENT.—What will you do with this report?

DR. KILBOURNE.—I move that the report of the Committee on Statistics be laid on the table.

DR. BRUSH.—I would make an amendment to that motion, that the report be received, accepted, and the thanks of the Association extended to the committee.

Motion seconded.

THE PRESIDENT.—The first motion not having been seconded, the amendment will be acted upon as an original motion.

Dr. Brush's motion was carried.

THE PRESIDENT.—The first three papers on the program this morning will be discussed together at their conclusion.

The following papers were read:

"Phenolsulphonephthalein Absorption from the Subarachnoid Space," by Paul G. Weston, M. D., Warren, Pa.; "Four Mongolian Idiot Brains," by Oscar J. Raeder, M. D., Boston, Mass.; "The Structural Brain Lesions of Dementia Præcox," by Adeline E. Gurd, M. D., Ann Arbor, Mich.

The above papers were discussed by Drs. Cheney, Gosline, Williams, Weston, Raeder, and Gurd in closing.

DR. COPP (presiding).—The next two papers will be discussed together.

The following papers were read:

"Studies on a Case of Hypo-Pituitarism," by H. D. Newcomer, M. D. and E. A. Strecker, M. D., Philadelphia, Pa., read by Dr. Newcomer. Discussed by Drs. Raeder, Bond, and Newcomer in closing. "Plots in Psychiatry," by Donald Gregg, M. D., Wellesley, Mass.

DR. COPP (presiding).—The members of the Council are asked to meet for a short session immediately after adjournment.

The meeting is adjourned.

AFTERNOON SESSION.

The President called the meeting to order at 2.30 p. m.

THE PRESIDENT.—I will call for the report of the Council.

REPORT OF THE COUNCIL, JUNE 3, 1920.

The Council recommends the election to associate membership of James M. Robbins, M. D., Philadelphia, Pa.

The Council has received and considered the applications of the following named physicians for active membership in the Association. In accordance with the provisions of the Constitution, final action will be deferred until next year:

Bruce Allison, M. D., Fort Worth, Tex.; W. J. Johnson, M. D., Rusk, Tex.; Louis A. Miller, M. D., Toledo, Ohio; Clarence B. Farrar, M. D., Ottawa, Canada; David H. Morgan, M. D., Akron, Ohio.

The Council makes the following recommendations:

That an honorarium of \$50 be given Dr. McMasters, who delivered the annual address on Wednesday evening.

That the time limit for the reading of papers hereafter shall be twenty minutes, and five minutes for individual discussion.

The Council appointed G. Alder Blumer, M. D., of Providence, R. I., as a delegate to the Semi-Centennial of the Society of Mental Medicine with power to name an alternate.

Respectfully submitted,

H. W. MITCHELL, *Secretary*.

THE PRESIDENT.—What will you do with this report?

DR. DEWEY.—I move the report of the Council be accepted and adopted.

Motion duly seconded and carried.

THE PRESIDENT.—Dr. Brown has a resolution to offer.

DR. SANGER BROWN.—At the last meeting of the American Medical Association in New Orleans, I presented a paper before the section on Nervous and Mental Diseases, entitled "Outline of a Scheme for Writing the Natural History of Syphilis." At the end of that paper I submitted the following preamble and resolutions and they were adopted. My purpose in bringing this subject before this Association is that if we can get a number of different organizations to endorse the project we will be better able to secure funds for carrying out the scheme. Only a little reflection is necessary to convince one that large funds will be necessary to carry the thing to successful completion, and of course physicians should not be asked to contribute those funds. We hope to secure the interest of some of these wealthy Foundations in the project:

"Whereas, The deleterious effects of syphilis on the mortality and morbidity of the human race are so prevalent and so severe as to challenge the most serious attention of the entire medical profession; and,

"Whereas, In the scientific study of any disease, knowledge of its natural history is an item of cardinal importance; and,

"Whereas, Owing to the protracted course of syphilis, a continuous and complete clinical record of a given case can be secured only through the services of several successive medical observers; and,

"Whereas, It is highly desirable that a sufficient number of completed histories be accumulated and preserved, and made easily accessible to students; and,

"Whereas, For the successful accomplishment of the purpose set forth above, the interest and cooperation of a considerable number of the best elements of our profession as represented in the membership of the American Medical Association are necessary; therefore, be it,

"Resolved, (1) That the Section on Nervous and Mental Diseases of the American Medical Association recognizes the importance of ascertaining the natural history of syphilis and of making this history accessible and in form serviceable to students of medicine; further,

"Resolved, (2) That the Section on Nervous and Mental Diseases of the American Medical Association respectfully requests the trustees of the American Medical Association to appoint a committee from the sections most immediately concerned, whose duty it shall be to devise practical means and methods of accomplishing the foregoing specified purpose; and further,

"Resolved, (3) That the representatives of this section in the House of Delegates be requested to present these preambles and resolutions to the House of Delegates, and to ask its endorsement."

DR. SINGER.—Mr. President, I think one can conceive of no subject which is worthy of more intensive study than that of syphilis. It comes in close contact with every member of this Association. The plan proposed here concerns the collection of data concerning persons infected with syphilis over a long period of time—from the time of infection until

death occurs. It is a measure that is going to take many years before definite results will be achieved, but without some such scheme we are always going to be left in exactly the same condition we are in now. We know that a great many conditions are due to syphilis, but we know little as to the treatment that has been applied and especially of the secondary and less obvious results.

I would, therefore, move that this Association endorse the program suggested by Dr. Brown, and adopted by the American Medical Association.

Motion seconded.

THE PRESIDENT.—Those in favor of this motion will please signify by aye. Opposed, no.

It is so ordered.

THE PRESIDENT.—Instead of having the report of the Committee on Occupational Therapy now we will postpone it until we hear the report of the Committee on Awards—we will have this report now, Dr. Fordyce, Chairman.

REPORT OF COMMITTEE ON AWARDS.

The Committee on Awards of Occupational Therapy begs to report as follows:

The Chicago State Hospital has a very complete and a most excellent display, and is awarded highest honor.

Watertown State Hospital, Ill., ranks first in Group One—showing the development of skill and interest with consequent improvement of individual patients.

Kalamazoo State Hospital, Mich., ranks first in Group Two—Articles showing the utilization of waste.

Jacksonville State Hospital, Ill., ranks first in Group Four—charts or diagrams showing the organization and management of occupation.

Saint Elizabeth Hospital, District of Columbia, ranks first in Group Six—record forms.

Danvers State Hospital, Mass., ranks first in Group Seven—plans or photographs of work rooms.

Other institutions deserving of special commendation are:

Manhattan State Hospital, New York; Kings Park State Hospital, New York; Elgin State Hospital, Illinois; South Carolina State Hospital, South Carolina; Massillon State Hospital, Ohio; Homoeopathic State Hospital, Pennsylvania; Butler Hospital, Rhode Island; Napa State Hospital, California; Mercyville Sanitarium, Illinois; Milwaukee Sanitarium, Wisconsin.

The exhibit is large and diversified, and shows that occupational therapy is being carried on in the institutions represented, in a very gratifying manner.

O. O. FORDYCE, M. D., *Chairman*,
R. H. HUTCHINGS, M. D.,
EDITH SPAULDING, M. D.,
MRS. E. N. BRUSH,
MRS. OWEN COPP.

THE PRESIDENT.—There is nothing to add to this report. We will now proceed with the afternoon's program. The first paper is "A System of Classifying Neuroses and Psychoses According to their Affective Mechanisms,"* by Edward J. Kempf, M. D., Washington, D. C. Discussed by Drs. Burr, Hamilton, Gosline, and Kempf in closing.

The following papers were read:

"Malingering and Simulated Disease," by Tom A. Williams, M. D., Washington, D. C.; "A Study of the Diagnoses in Cases at the Psychopathic Department and Hospital Department of the Boston State Hospital," by Lawson G. Lowrey, M. D., Boston, Mass. Discussed by Dr. Raeder and Dr. Lowrey in closing.

THE PRESIDENT.—I will now call for the report of the Committee on Occupational Therapy, Dr. Gahagan, Chairman.

REPORT OF COMMITTEE ON OCCUPATIONAL THERAPY.

To the Members of the American Medico-Psychological Association:

The Committee on Occupational Therapy regrets to announce the death of our esteemed and honorable chairman Doctor Crumbacker who passed away at his home at Independence, Iowa, on May 14th, 1920. Doctor Crumbacker's death was a shock to his co-workers on the committee with whom he had been so closely associated and particularly to the members of this Association.

Our beloved friend had been so untiring in his efforts that his work was completed and the success of the Exhibit was assured. A circular letter was mailed outlining a scheme for the Exhibit, as follows:

1. Showing the development of skill and interest with consequent improvement of individual patients.
2. Articles showing the utilization of waste. These may be more interesting if progressive steps are shown, such as the raw waste, its reclamation, preparation for the new manufacture and the finished articles.
3. New or original methods of occupation.
4. Charts or diagrams showing the organization and management of occupations. Some of these may be suggested by the accompanying questionnaire.
5. Charts or diagrams illustrating the progress of patients or of groups.
6. Record forms.
7. Plans or photographs of work rooms.

Practically anything which will be stimulating and helpful will be welcome, but the committee reserves the right to reject anything which it deems unsuitable, and also the right to arrange the exhibit as it deems best.

* This paper was accepted by the Committee on Program in ignorance of the fact that it has been published in a medical periodical in September last. It will not therefore be published among the papers read at the meeting, nor will the discussion appear in the *Transactions*.

Certificates will be awarded as usual to the three groups of

1. State hospitals.
2. Incorporated hospitals.
3. Private hospitals.

The committee appreciates the labor involved in answering the following questions, but it hopes that you also appreciate how much the summary of this information may benefit others. It will, therefore, be grateful for the trouble you may take in answering the questions, and also for any other information which you may give.

A questionnaire was submitted, 52 replies were received containing the following data:

1. Is there special provision for occupational therapy in your hospitals

Answer. Yes, 37; no, 15.

2. If so, please describe it, stating its organization, the number of teachers, salaries paid, cost per capita of the patients attending, and cost per capita of population. It is agreed that such information shall be confidential to the committee.

Answer. One teacher 10 to 150 patients. Salaries, chief occupational therapist \$75 to \$175 per month; assistants, \$35 to \$50 per month.

3. What is the average number of patients occupied? Of women patients?

Answer. Fifty per cent more women than men.

4. What percentage of the population do these numbers represent?

Answer. From 3 to 50 per cent.

5. What number are considered acute cases.

Answer. Chronic types exceed acute three to one.

6. What number are considered chronic cases?

Answer as above.

7. What is the average number of hours that individual patients are employed? Maximum? Minimum?

Answer. Average four, maximum six, minimum two hours.

8. What forms of work have proved most beneficial?

Answer. Women: Embroidery, needle work, fancy work, lace, weaving, leather. Men: Woodwork, basketry, metal, brass, gardening, toys, weaving.

10. Are records kept of the attendance, or other points of each class?

Answer. Records kept in twenty-four hospitals reported.

9. Are records kept to show the progress of individual patients?

Answer. Records kept in 20 hospitals reported.

11. Is the medical and nursing staff responsive in securing results?

Answer. Yes.

12. Does non-restraint, removal of bars, neat and attractive clothing, table ethics and home surroundings better or stimulate the patient for occupation?

Answer. All replies in the affirmative.

13. Would better results be attained by having the trained worker in Occupational Therapy a member of the nursing staff, and could not this training be received in the curriculum of study in the training school?

Answer. Thirty, yes. Seven, no.

14. Has Occupational Therapy reduced the number of untidy patients in the hospitals?

Answer. Thirty-six, yes. Five, no.

Seven of the 15 hospitals reporting no special provision for Occupational Therapy, expect to institute same within a year, the remaining eight of this number are short of teachers. The cost per capita was difficult to ascertain and impossible to establish as a whole. Twenty of the 37 hospitals are giving more or less intensive training, consequently their per capita cost is high. Very good work is reported where Nurses trained in occupational work are assisting a trained therapist. A number of superintendents suggest a training in the hospital curriculum supplemented by a post graduate course in occupational therapy.

Questions number 11, 12, 13, 14, were answered generally in the affirmative as was expected. Habit classes are established in several hospitals, as was expected. Habit classes are established in several hospitals, this phase of the work is most essential and should be encouraged, the whole basis of this great work lies in the effort for reclamation of the retarded shut-in type. To get results and save these unfortunates for a proper adjustment, one must know them. Personal interest is the theme, kindness and a cheerful demeanor to the clod-like arouses them from their lethargy. Let us not while away too much time on classification, let's do something for the patient.

The work of women in occupational therapy is most meritorious and an important field for their endeavor, we welcome their noble efforts. The exhibit in an adjoining room is indicative of the splendid results accomplished. The certificate of merit granted by this association is an incentive to the classes for future progress and recognition of the zealous and patient labor of the teacher. Occupational therapy in all its phases is demonstrated in this exhibit, from the habit classes to the kindergarten, and by progressive steps fitting the patient for life on the outside or for the industrial department of the hospital. The provisions of the committee have been complied with in this exhibit. Fifteen hospitals of eight states are represented in a wondrous display of articles. The committee is thankful to Mrs. Eleanor C. Slagle, superintendent of occupational therapy, of Illinois and her aids, Miss Anna Tomkins, Miss Mary Shanklin also to Miss Marian Spear, occupational therapist of The Kalamazoo State Hospital, and Katherine Staples of The Cook County Psychopathic Hospital, Chicago, for their assistance rendered in setting up the exhibit. The hotel management has been very courteous in supplying help and equipment for which we are grateful.

Respectfully submitted,

H. J. GAHAGAN, M. D.,

Chairman Committee on Occupational Therapy.

DR. COPP (presiding).—This report presents a very important subject; it will be received and printed in the Transactions of the Association.

The next paper is entitled "A Review of the Five-Year Period Following Admission in One Hundred and Eleven Mental Patients," by Earl D. Bond, M. D., Philadelphia, Pa.

Discussed by Drs. Burr, Brush, Copp, Mitchell, Gosline, and Bond in closing.

DR. COPP (presiding).—We have time for two more papers this afternoon.

The following papers were read:

"A Study of Undiagnosed Cases, Chicago State Hospital, for the Year 1919," by Charles F. Read, M. D., Chicago, Ill.; "Physiological Psychiatry," by Seymour DeWitt Ludlum, M. D., Philadelphia, Pa. Discussed by Drs. Dunham, Harding and Abbot.

Adjournment.

FRIDAY, JUNE 4, 1920.

MORNING SESSION.

The session was called to order at 10 a. m. by President Eyman, who announced the election of members as the first business before the Association.

THE SECRETARY.—These names were presented to the Council, approved by that body and recommended for election as Associate Members of the Association. I will read the list.

The Secretary read the following list:

Harold W. Brann, M. D., Cleveland, O.; Charles H. Creed, M. D., Columbus, O.; Charles Englander, M. D., Cedar Grove, N. J.; Paul J. Everhardt, M. D., Towson, Md.; Ola A. Kibler, M. D., Illinois; Richard S. Moynan, M. D., Cleveland, O.; Frank G. Norbury, M. D., Jacksonville, Ill.; G. Blake Smith, M. D., Godfrey, Ill.; John M. Thompson, M. D., Cedar Grove, N. J.; James M. Robbins, M. D., Philadelphia, Pa.

DR. G. W. BROWN.—I move that the Secretary be authorized to cast a ballot for the election of these names just read in our hearing.

Motion seconded and carried, and the Secretary announced that the ballot had been cast and the members duly elected.

THE SECRETARY.—The membership of the Association as tabulated in our list of members is 933; there have been elected at this meeting 43 active members and 54 associate members, making the total membership 1,030.

THE PRESIDENT.—The first paper on the program this morning is "Treatment of Epilepsy," by C. C. Kirk, M. D., Little Rock, Ark.

Dr. Kirk's paper was discussed by Drs. Jones, H. W. Mitchell, Swint, Ross, and Kirk in closing.

THE PRESIDENT.—We will now listen to a paper by Dr. Albert M. Barrett, of Ann Arbor, Mich., entitled "The State Psychopathic Hospital." From the charts displayed I believe it will be a very interesting contribution.

Dr. Barrett's paper was discussed by Drs. Burr, Dewey, Brush, Kirk, Copp, Ostrander, Kilbourne, and Barrett in closing.

THE PRESIDENT.—We will now hear the report of the Committee on Resolutions, Dr. Brush, Chairman.

REPORT OF COMMITTEE ON RESOLUTIONS.

Your Committee on Resolutions, departing in some measure from the practice of former years, wishes first: To congratulate the Association upon the character of, and attendance at, the meeting which is drawing to a close.

The 76th annual meeting has set a precedent for those which will follow in the last quarter of the first hundred years of the Association's existence.

To the Programme Committee and especially to its efficient and untiring chairman we are under great and renewed obligations, and to Dr. Orton and his associates our thanks should be extended.

The Round Table Conferences, first instituted a year ago have so thoroughly proven their value and have given such general satisfaction that it is hoped they will be continued at future meetings.

The discussions at these conferences, though informal, have brought out so many points of value, that the presence of a Secretary with each circle might well be considered, to report an abstract of the various discussions for publication in the proceedings of the meetings.

To the Cleveland Chamber of Commerce we are indebted for various kindly and thoughtful acts, among them the presentation to each member of an illustrated pamphlet descriptive of the City of Cleveland.

The arrangements for the meeting room and for a place of registration, committee rooms, etc., made by the management of the Hotel Statler have been admirable, and have contributed much to the success of the meeting and the comfort and convenience of those in attendance.

We have missed the presence of one who has for forty years been a regular attendant at our meetings and who as the first secretary of the reorganized Association, 26 years ago, as editor of the first volumes of our *Transactions*, editor of the *JOURNAL OF INSANITY*, President of the Association and the editor of those four important and epoch-marking historical volumes "The Institutional Care of the Insane in the United States and Canada" has placed the Association, the profession and the public under everlasting obligation. We rejoice that Dr. Hurd still retains his interest in us and our work as manifested in the charming letter sent and one of the Round Table Conferences, and convey to him our affectionate greeting and the hope that he will attend many future meetings.

Death has invaded our ranks and chosen shining marks for his arrows during the year. Cowles, the first President of the reorganized Association, Searcy of Alabama, President in 1912-1913 and Southard, who presided over our sessions last year have all died since we last met.

The first two died in the fullness of years and of honors, their work well done, their course ended. Southard, suddenly called from us in the fullness of manhood had, like Cowles, who was his exemplar in many things, left a lasting impression upon psychiatry and had done much to elevate the standards of our special work.

Hoch, who was also associated with Cowles, and whose work has made an imprint upon the records of psychiatry which will be an enduring one, had retired from active work by reason of impaired health, but his friends and associates hoped that rest and quiet would permit him to realize his cherished wish for an opportunity for literary work, from which much was anticipated. Our hearts have been saddened by the departure of these and other cherished associates. Their memories will be among these which we cherish.

The members of the Committee of Arrangement for the Cleveland meeting have not contented themselves with the mere material preparations for the various sessions which was bountiful but have been indefatigable in looking after the comfort of every one in attendance and we owe to them our heartfelt gratitude.

To Dr. Eyman the President both congratulations and thanks are due. Congratulations upon the character and success of the meeting over which he has so well presided and whose deliberations he has so successfully conducted—and thanks for the many and happy and if we may use the expression Eymanesque ways in which he has made our sojourn here in the city by the lake a pleasant one.

Finally your committee, composed of members all of whom have been for more than a quarter of a century connected with this body sees causes for most profound congratulation and for predicting a steady growth in the effective force of the Association, in the increasing interest our younger members are showing in its work, and in their most valuable contributions to the programme and to the discussions.

(Signed) EDWARD N. BRUSH, *Chairman*.
RICHARD DEWEY,
CHARLES H. BANCROFT.

THE PRESIDENT.—*Members of the Association:* The time has now arrived for me to lay down the responsibilities of this office. I think we can say that we have had quite a successful meeting. I want to thank each one of you for your courtesy and kindness and for the interest you have shown in the proceedings, and the love and esteem you have manifested toward me personally. It shall ever be a precious memory in my heart.

I want to acknowledge publicly my indebtedness to the Secretary for his especially happy help.

I will ask Dr. English and Dr. Clark to escort Dr. Copp, your new President, to the rostrum.

The President-elect was escorted to the platform amid prolonged applause.

THE PRESIDENT.—Dr. Copp, the time has now arrived when I turn over to you this gavel, this badge of authority, and I do so willingly and gladly because I know that in your hands it will never be used improperly. I also want to say that those over whom you will preside next year, I promise you, will give you the same love and esteem they have given me this year. (Applause.)

THE PRESIDENT-ELECT.—*Members of the Association:* I thank you for this great honor—the greatest that has ever come to me. Nothing that I have done has merited this honor, I can only attribute it to the great generosity and kindly spirit which has always characterized this Association, and which characterizes the administration of all our hospitals. I shrink from the responsibility. How can we expect to equal or approach the standard of this meeting? Men have been coming to me and saying “This has been one of the best, if not *the* best meeting the Association has ever held.” To try to approach the standards of Dr. Eyman makes me shrink from even the attempt. When I look back at the men who have occupied this chair, and the achievements of this Association, then it seems like trying to assume an impossible task. I sometimes read the annual reports of Dr. Kirkbride, the first Secretary of this Association. I am astonished at his progressive ideas and aspirations and am ashamed of the efforts and the accomplishments of the present time as compared with those early days.

Aside from the personal satisfaction I feel, the honor that you have conferred upon me, and the shrinking from the task that must be undertaken, there is another aspect in which I can, and am glad, to share with you, every one of you—the obligations and duties which none other than this Association can assume. We have committed to us a great trust. More than 300,000 patients in our institutions are dependent upon us for their comfort, their happiness and welfare. If we do not befriend them, there is no other recourse. We are responsible for expending every year more than 75 millions of dollars. If we are faithful to that trust, to its economical expenditure, we are saving just so much for their benefit.

More than 50,000 new patients come under our observation and treatment every year. We are responsible for their examination, understanding and treatment. Every one of these patients is dependent upon us for the best chance of regaining health and re-assuming their places of usefulness in the community.

Now, much as we have accomplished in the past, we are entering upon new tasks in the natural advance of progress. We must get away from the old association with poor relief, charity and correction. We must come into association with health, mental hygiene, prevention and adequate hospital treatment. We must be hopeful because we are dealing with a matter that has just as many elements of success and achievement as are presented in any other field of medicine. We, ourselves, know what the institutions and the men associated with them are doing. People come to our hospitals and say “We are astonished at what you are doing.”

That remark has been made of this Association by men who have come here for the first time. Not everybody knows this. They do not know it because they do not come into immediate contact with us and we do not exploit our work quite as much as we ought for the enlightenment of the community.

We are going to Boston next year; that is going home to me, and it is going to a very interesting place for you. I want to offer the suggestion that every one bring to that meeting hopefulness, enthusiasm and ideas of progress. The success of that meeting will depend entirely upon you. Let us all work together. (Applause.)

Will Dr. Ostrander preside at the piano and lead us in the singing of "America"?

The members and guests arose and joined in singing, accompanied by Dr. Ostrander at the piano.

THE PRESIDENT-ELECT.—The meeting is adjourned.

The Association adjourned at 12.30 p. m. to meet in Boston, Mass., in 1921.

H. W. MITCHELL, *Secretary.*

PRESIDENTIAL ADDRESS.

By HENRY C. EYMAN, M.D., MASSILLON, OHIO.

Members of the Association, Ladies and Gentlemen.—It becomes my duty as president of the Association to address you. "For a whole year such a thing as serenity of soul is unknown to the man who awakes to find greatness accidentally thrust upon him as president elect of an association like this." So spoke the great G. Alder Blumer, and I most cordially agree with him. At least, I have not the slightest fear of being placed in the position of the man who received a high appointment, and went to the appointing power to get instructions and received this admonition, "Young man, you are going into this with laurels on your brow, have a care that you do not browse upon your laurels." In the beginning, I wish to thank you again for the high honor you have conferred upon me by your suffrages and to beg your indulgence, and solicit your aid while I endeavor to discharge to the best of my ability the duties devolving upon this office, the highest within your power to give. I am especially glad to welcome you to this my home city, this beautiful Forest City on the banks of the renowned Lake Erie. In the seventy-five years existence of our society, nearly every field has been entered and pretty thoroughly cultivated—nearly every subject related to our specialty clothed and rehabilitated and threshed and threshed again until it seems an herculean task to even find a subject for a presidential address. To you who have not gone through the ordeal this may seem a trivial matter, but when you have been placed in a position where the preparation becomes a necessity, when you have wooed in vain the Goddess Lucina, but never an idea was born, when you have used up gray matter sufficient to govern a country or write a Peace Treaty, in a vain attempt to reach the high mark set you by those who have preceded you, then you may be willing to agree with the preacher, "Vanity of vanities, all is vanity." I thought of the "Physician in Literature," then was confronted by the erudite address given by my most intimate friend at Boston

in 1906, and the entrancing manner in which he told us of the good old doctor described by McLaren in "Beside the Bonny Briar Bush," and dozens of other characters in history and in fiction all woven and interwoven into a classical whole, the field looked so well cultivated that I despaired. I thought of the medico-legal aspect of our specialty, and was at once made aware that that subject had already been the topic of at least two presidents in their addresses. Then my mind harked back to the erstwhile important subject of the unfit and the problematical location of the river Eugenie, and here I found that this subject had been thoroughly grilled by a master mind and a past master in phrase making. The care and treatment of the insane in the United States, in New York, in Canada, and in fact everywhere, has been so exhaustively treated that it is well-nigh impossible to say anything new, and I am ready to exclaim with Bill Nye, "Shakespeare stole all our best thoughts." Our versatile president of one year ago lighted the lamps which had been located along the line of our work, marking off the decades. His review of the important things which these lamps lighted up was so complete and full that even Coxey's army received honorable mention, therefore, to attempt to find anything in the past left unsaid by him is futile. Of course, I might go to the "Institutional Care of the Insane" in United States and Canada, and copy page after page, and find it good reading too, but maybe some of you are already familiar with it, so that is barred. In lieu of topics, I have felt constrained to discuss topic-makers, but even this would be considered too personal. Therefore, having exhausted the field of topics about all that is left is to look carefully as to the interpretation of recent events, and anticipate as far as possible what the future holds for us from a psychiatric view-point. These are days which involve heavy burdens and vast shifting solitudes. These responsibilities devolve upon you and upon me. They cannot be met by dipping our pens in the bitter fluid of satire. We must meet them out in the open. There the subtleties become the proper field for the fight of the psychiatrist, and it behooves each one of us to put on the armor of the just and harness these isms and fancies and force them to tread legitimate channels. Much has been spoken and written about a changing world. 'Tis true

the night of tomorrow will soon vanish into the night of yesterday, and the pendulum of last week may swing into the pendulum of tomorrow, yet the duty of real psychiatry is to use its influence in keeping the pendulum from swinging too far. This cannot be done simply by terminalogical inexactitude, there must be real scientific effort, and you know success only comes to those who rush out to meet it. The clock of achievement is set to a heart-breaking schedule; it demands from you perpetual working of the brain, and after all 'tis not the victory that matters, 'tis the fight. He who waits to have his work laid out, dies and leaves his mission unfulfilled. The present is merely a brief approach to the future. Our beloved Southard defined our responsibilities for the future very clearly in what he termed eudemics, eugenics, euthenics. The first is public, synonymous with governmental; the second, social—which includes agencies and interests not yet organized. The third, personal, individual in progress. In the first, we have in mind institutional improvements, public service type. In the second, social uplift; in the third, individual progress toward self realization. Many physicians have the moralist idea in their heads when they inveigh against the social uplifters and their proposals for safe-guarding society and particularly harden their hearts against the public service men. In order to obtain the greatest good in this field of endeavor, it will be necessary that these uplifters be able to differentiate between medico-legal conditions known as insanity, and the purely medical known as psychopathy in one of its various forms. In this they will be greatly aided by the psychiatric clinics which can now be found in many of our cities, especially eastern cities. Then there are environmental misfits, self explanatory. Then the non-environmental conditions where there is either a loss of self-control or a pathological self-control, that is controlled by delusions, etc. These cases remain outside of institutions at least for a time and become a part of the clientele of what Dr. Salmon calls "itinerant alienists." And here we must consider the efficacy or non-efficacy of what we know as psycho-analysis, incest complex, the developmental scheme, etc. The developmental path is the same for all of us. How far have we progressed along that path? Our Washington member says Freud used psycho-analysis to unravel the

past. The genetic concept of the psyche—a psycho-sexual development—has forever relegated mere descriptive psychology of the psychoses and neuroses to the background and raised psychopathology to an interpretive level—a level in which the symptoms are no longer accepted at their face value, but only in the light of their meanings. The will to show power is probably the reason we have the great desire of all the world to masculinity, and accounts for the militant suffragist. Even the cortex becomes the inferior organ, and such chemical concepts as that of hormones, as energy distributors become the hierarchy. We never see the individual as he really is. We cannot see the real personality within. He is never as bad as he is sometimes painted by the realist, nor as good as the idealist would have us believe. Good and bad are relative terms indicating success or failure. The old saying “nothing succeeds *like* success,” should be made to read “nothing succeeds *but* success.”

Psycho-analysis endeavors to strike at the root of appearances—to deal with essentials and not with surface indications. Then our erudite and greatly beloved president of a year ago comes along and calls the claims of the psycho-analysts—a phagocytosis of theories and thinks we should look with suspicion upon all hyphenated libido. The speaker is not expressing an opinion, merely endeavoring to chronicle theories and claims as made by some of our most brilliant members.

There has been another positive advance in the school of psychiatry, in that formerly the clinical study of the patient was of paramount importance, whereas now the laboratory comes in for an even greater share. Working theories have changed with such rapidity that it is almost impossible to enumerate them. Nomenclature has become almost absurd, and at times we are quite certain that we should go back to the tentative plan advocated by our beloved contempore, the venerable Dr. Cowles, whose memory we all revere, when he stated that there were but two forms of insanity—one being dementia præcox, the other not. At any rate, names amount to little more than labels stuck on for convenience of discussion. I think we still have two schools of psychiatry—but I would divide them into those who make thorough examinations, bringing to bear *all* the appliances of

the clinic and laboratory, and those who depend wholly upon observation and do not trouble to make thorough examinations, but make a tentative diagnosis and stick to it, and there are many such.

Many years ago, Dr. Adolf Meyer said, "I am convinced that the progress of medical work depends not upon the mere introduction of a man with skill for microscopical work, but on the promotion of the spirit of accuracy in whatever work is done, and in whatever is written or said about the patients. The various hospitals should be able to encourage their assistants to conduct all the practical medical work according to acknowledged medical standards. Every assistant should thus acquire the habit of planning accurate statements of facts, statements of the indications for action and opinions, and also the nature of disease, its probable course and the possibility of introducing therapeutic measures; and in the case of an autopsy, the methods of getting at the facts and formulating indications for more minute investigations. In addition to this, the physicians ought to be encouraged to record which might be an advantage for collateral scientific progress even if they cannot be directly utilized in the special case or for the specific medical indications just mentioned." I wonder if we have yet caught up with the spirit of Dr. Meyer. The trouble with us all is that we frequently cling to the "ism" rather than to a scientific fact established by laborious research. Some of the most captivating theories are most dangerous. I have no quarrel with those clinging to their pet isms or theories. An argument you know is only a statement of beliefs and as no one gives up his belief, therefore an argument is only a pastime and accomplishes nothing. I am reminded of an argument I once had with a young lady while on board an ocean liner. She believed in spiritualism with the accent on the *ism* and unwittingly I was drawn into a conversation with her. In attempting to prove that mind and thought were material, I was interrupted with the sarcastic remark that it could not be true as nothing was material. I said, "not even this ship, not even you?" "No indeed," was the answer, "if I did not think this ship was here it would not be here." Well, what's the use? Without a premise nothing can be proven. To say nothing is material is as foolish as to say that

all things are material. Isn't it strange that the physician, the man who studies even the anatomy of this body of ours, should be a materialist? To watch its workings and then doubt the God who made it is sheer willful blindness. Oh! you materialist with shaky nerves, bleary eyes and uncertain gait, do you think you are reflecting glory on the mother who bore you by proclaiming "there is no God," and exhibiting your nerveless anatomy as proof of the assertion? I am enough of a spiritualist to believe that the material body needs the aid of something other than mere drugs to keep it pure. The mountain stream at its source may be pure, but it will not remain so if impure streams are emptied into it. The toxins in your body must be eliminated by the aid of drugs, but no amount of drug taking, however potent, will keep you clean and pure without your constant effort. The God that made and formed you, and provided you with strong nerves and a pure body, will aid you in caring for them, but no matter how pure the mountain stream at its source, yet if you constantly pour your sewage of corrupt habits and practices into it, the whole stream becomes contaminated. We must admit that certain "isms" which we are fond of condemning in a wholesale manner, do get results in some cases, and a recent president of this association once said, "pragmatism is essential to a successful life," therefore, we should not content ourselves by poking fun at anything that gets results. We must acknowledge that worry and fret and anxiety are largely removed by the "ism" of Christian Science, and as a Baptist clergyman describes man—"He is a worried and fretted and fearful man, afraid of himself and his propensities, afraid of colds and fevers, afraid of treading on serpents of drinking deadly things" and this answers for the whole human race. We have always been loth to believe in the hierarchy of the mind. While all of us can give instances and multiplied instances where this most important fact has been thrust before our vision, yet we are prone to explain them away on some ground other than the influence of mind over matter. We believe the trend of scientific opinion to-day is toward the theory that mind is matter and, therefore, that it is only the influence of the stronger over the weaker part of man. We do know that by this influence man is lifted out of the slough of despond and the valley of despair, and is

now basking in the splendor of the sun-kissed mountain top. Anything which will enable man to divert his mind from unhealthy channels and force it to travel in healthy ones is a benefit to the human race, and it will not suffice us as physicians, philanthropists or psychiatrists to dismiss this idea as absurd and without importance. It becomes our duty as mental specialists to harness this modicum of truth and compel it to do legitimate work in harmony with real science and real philanthropy in every other line. If the followers of certain cults step in, and using a grain of truth and real science and a ton of jugglery and pseudo-science are able to sound depths of the emotional life entirely unsought by us, and in consequence not only attract people, but in instances get results, and we content ourselves with laughing at their methods and make no effort to separate for the edification of the people, the real from the false, then we are certainly culpable, and are really aiding these various cults to thrive and flourish, and alas, frequently destroy. The psychiatrist, the preacher and the philanthropist must grasp the underlying unity of the spiritual and material and recognize that the body may and does influence diseases of the soul, so does the mind influence states and diseases of the body. The most eminent and successful physicians and ministers have all been psychologists. Many of them are perhaps what we may term unconscious psychologists, aye even unconscious hypnotists. You all know how a minister with a cordial handshake and a benevolent looking eye, can inveigle you into subscribing a little more to the new church than you had thought you could afford. Mere drugs or sermons or contributions of money without the soothing touch, the kind encouragement of the heart accomplishes but little. The personal equation enters into every successful effort. It is personal help we all want. You may have heard the story of the good old Quaker who died leaving all his property to his three sons, James, John and Charles. His property consisted in part of 17 oxen. To James he willed one-half the oxen and no ox to be killed; to John he willed one-third the oxen and no ox to be killed; and to Charles he willed one-ninth the oxen and no ox to be killed. The boys were in a quandary and could not figure out how to comply with the father's will. A good old Quaker neighbor learning of the difficulty, said to himself, "I will mount old Oxbright and ride

over and help the boys." So he bestrode old Oxbright and rode over to the farm. He said to the boys. "I have heard of your knotty problem and I have come over to lend you some personal help. Your father left to you, James, one-half the 17 oxen. Now evidently you cannot get the half of 17 without destroying an ox, so I'll just turn old Oxbright into the herd. Now, James you take your half which will be nine oxen, and John you take your third which will be six oxen, and Charles you take your ninth which will be two oxen. Now 9 and 6 and 2 are 17, you have divided the oxen as your father willed and I will bestride old Oxbright and go home again." We all need personal help. The laboratory man, the pathologist and the clinician, each needs the help of the other to accomplish the greatest good, and I think the tendency of the present is toward a recognition of this great fact. There is a physical, a material, part in medicine but there is also a mental factor, which, though we are sometimes inclined to ignore, nevertheless does exist and the ability to use this mental factor, sometimes means all the difference between success and failure. And harnessed up so closely with this mental factor in the life of the successful practitioner that it is impossible to separate them, is that other factor which does so much to move the world, enthusiasm. Enthusiasm is contagious. Hard work without enthusiasm never stirred the pulse of the world nor fired a human heart. Suppose your pathologist does become a little too enthusiastic concerning some problematical discovery, and leads us into error, is it not better to encourage him in his efforts even though sometimes he errs than to have him stand still? Genius is the child of enthusiasm, but it remains a child and dies mute and inglorious unless clothed with action and crowned with persistence. We must not allow our research work to lag for want of encouragement. Mental force—intense optimistic thought is real dynamite and blasts an opening through impassable rocks. And in the end truth must prevail because the purpose of creation is that every atom shall work out its individual destiny by individual effort, and herein lies the weakness of all the cults which ignore this great overwhelming fact. Upon this is built the progress of the world, whether in the field of medicine, the field of research or of any allied science, and all things failing to recognize this must be crushed by the wheel of

progress. Optimism is one of the great forces of nature, but indiscriminating optimism may bring really meritorious methods into disrepute. How far the emotions, imagination, expectation, faith, hope, joy, terror, may control the bodily functions has not yet been determined. Epilepsy may be cured by great shock. I have frequently seen seizures aborted by sudden fright. A lady who had been suffering from epilepsy for years received so severe a shock upon beholding her beloved daughter die from the effects of dreadful burns, that she never had another attack. Contractures of long standing succumb to the mental factor. Patients often experience great relief the moment the thermometer is placed under the tongue. There is apparently no limit to the various kinds of ills which can be and have been cured by trick or jugglery, or imagination, or the influence of the will; but the real diseases which attack and destroy cell tissue need something more than incantation.

"The surest road to health say what you will
Is never to suppose we shall be ill.
Most of the evils we poor mortals know
From doctors and imaginations flow."

How sad that the writer of such beautiful verse should die of a fever at the early age of 34 years.

Rudyard Kipling tells of a practitioner who was likewise a devout believer in astrology, in the days of the great rebellion in England:

He comes into a little village devastated by the plague. He exhausts all the resources of the medical art of his time in vain; the people continue to despair and die. The physician therefore resolves to take counsel of the stars, through which he learns that the patroness of the pestilence is our Lady of Ill Aspect, the moon; and that the only hope for the dying people lies in the aid of the sun and the planet Mars. By chance the astrologer-physician sees some rats staggering and dying in the moonlight; and the idea of a connection between the rats and the plague flashes across his mind—not for a moment indeed that he entertains the idea that rats carry contagion, but that being creatures of the night, and therefore of the moon, the rats must be parties to the sidereal conspiracy of which the plague is the outcome. So the doctor brings his patients away back from the dark hovels and holes where they have been languishing and takes them into the sunshine and fresh air—not because the sunshine and fresh air are good in themselves, but because of the influence of the sun being opposed to that of the moon is the proper one to seek (and so was organized

the first fresh air camp). He organized a war of destruction against the rats (not as germ carriers, but as partners with the moon); and in the process of extermination all the dark and filthy places in the village are made light and clean. Not, of course, because such procedure is hygienic, but because it invites the favor of the sun and lessens the unfavorable influence of the moon. He caused the holes of the rats to be filled with slag from the village smithy—because the horse is a martial animal and Mars is a favorite planet. The people are aroused from their apathy and terrified inertia by the tasks set them; the village is cleansed and made hygienic, the rats are destroyed and the plague vanquished. The physician regarded with adoration by the grateful people of the village, with becoming humility ascribes all merit to the favorable stars.

This, at least, may be pragmatic. There is food for reflection in these glimpses into the past, as we attempt to peer into the future. I think sometimes we are apt to spend too much time looking at the stars and fail to see duty and progress at our feet. Of course, we would all like to be Southards or Blumers or Whites, we want to do something wonderful, something to attract the attention of the world, something corresponding, in the language of a great English philosopher, "to those splendid flashes of imagination which yielded the heliocentric theory of the planetary system, the theory of gravitation, the undulatory theory of light, the theory of evolution and the germ theory of disease. Some fundamental and far-reaching generalization in pathology and physiology which would vivify and vitalize some part at least of the mass of dead material facts which have been accumulated." What we really want is a patient optimism, which by its very persistence and stick-to-it-iveness removes the barriers of prejudice. It is difficult for us to see our own faults. "We shield the sins we have a mind to, by damning those we're not inclined to."

But what is the tendency of the times, what is our association doing to mould the mass of dead material facts into a scientific guide book for the coming generation? Well, we have placed upon a solid foundation the progressive ideas which have resulted in changing asylum care to hospital treatment. It is true that in some places there is a tendency to return to the old régime. There are places where human need fails in the race with the almighty dollar. We have made psychopathic hospitals a fixed principle. In a few years, we believe that no hospital will be permitted to receive new or recent cases unless equipped for the most modern examinations and the most improved means for

investigation of pathological conditions. No patient will be taken to the ordinary wards of any hospital direct upon admission. All the red tape, the legal unwinding of which sometimes results in tragedy, will be eliminated. Every hospital will have a psychopathic cottage or ward in which the patient can be placed, studied, examined and a real, though perhaps tentative diagnosis made *before* the legal commitment which deprives him of citizenship, his right to conduct his own affairs and oftentimes of his own individuality. In the cottages or wards he will be given intensive treatment, if it be the opinion of the psychiatrists after examination, that his condition is probably curable, or if he be in the incipient stages of disease. This cannot be done without proper provision. There must be an adequate staff of physicians, investigators and trained technicians in every department. Anything short of this is not enough. 'Tis a debt the fortunate owe to the unfortunate. In this manner the number of commitments to the wards of the hospital may be reduced 40 to 50 per cent, and the ultimate burden upon the taxpayer be greatly reduced. Upon the staff must be men with an intimate knowledge of the conditions which lead to the thing which we call insanity, and to associated conditions; and these men must have all the special equipment the modern laboratory can furnish. I think the psychopathic wards or cottages should go further and be used as community centers for the primary care and examination of all persons in that individual community who feel the need of advice for real or imaginary mental or nervous conditions and for those whose families or friends have had reason to fear the oncoming of disease. The trend of our work has shown nothing with more clearness than the necessity of many such clinical laboratories. Of course, there must be some legal process for even temporary care. If the patient will voluntarily place himself in such hospital for treatment for a specified period, that should be protection enough for those in charge—if entirely on the advice and insistence of relatives, then the simple filing of an affidavit of the family physician, that such care is desirable, should be sufficient. The period covered by such care should not be too short. In some places a period of seven days is given, and in many cases that is ample, but there are many cases that even the most modernly equipped laboratory and the best informed clinicians cannot

decide definitely in that time. I do not think that the law should be the sole arbiter. The exact length of time a given person should remain for examination and observation should be left largely to the medical staff—at least there should be considerable flexibility. Many persons are picked up on the streets by policemen, persons who are suffering from mental confusion delusions, hallucinations or delirium, who are not drunk, and who should be given the benefit of the best that science affords before being haled to the courts, as if for a sentence. This could be accomplished by means of an affidavit from the county physician. At the Pittsburg Home and Hospital this is carried out partially. Out of 173 admitted to the observation ward, only 52 were committed as insane.

In a paper read by Dr. May before this association last year, an analysis of the work done by the Boston Psychopathic Hospital, showed that for six years ending September 30, 1918, there had been 11,289 admissions and that 6499, or 57 per cent, were temporary cases and did not need commitment to the wards of a State Hospital. The paper also showed that 375 per year, of mental cases, came into the hands of the police of Boston. He also showed that there was an average of 331 voluntary cases per year. This proves that if given the opportunity in individual communities throughout the state, many more persons would avail themselves of the privilege and undoubtedly a great number of commitments be avoided. The consideration of per capita cost is becoming less a factor in the best hospitals. The people are perfectly willing to support our hospitals when they once learn that real progressive work is being done. Complaints of management have always been and perhaps always will be, all too common in every hospital in the land, but if effectual work is being done and results show this work to be of a high standard, I venture to say there will be a minimum of these complaints. The question has now become how well, not how economically, can they be treated. 'Tis no longer a question or problem of whether the individual patient shall be controlled by mechanical restraint or drug restraint—these questions have been relegated to the background, and in the more modern hospitals are seldom even referred to, but their substitute, scientific knowledge and how best to obtain and apply it, must now be threshed out. Training schools, laboratories,

industrial training and clinical study of individual patients, have now become an absolutely necessary part of the armamentarium of every hospital worthy of the name. And all this is directly due to the influence of this Association.

In his presidential address delivered at Old Point Comfort a few years ago, Dr. Smith said:

The history of this Association is the history of the care of the insane in America. It has guided it by slow stages from mere custodial care, through the infirmary and asylum to the modern day hospital, with its splendid household and medical equipment, its laboratories, diversions, occupations, re-educational and training schools, colonization, voluntary commitment, after care and anything and everything facilitating diagnosis and treatment with a view to the amelioration of the distress of mental disease, and restoration to health, home and society. This work has been well done and its accomplishment is a story of lifetime devotion and labor of love by a long list of distinguished members, living and dead, of this association.

Segregation as a means of prevention has long held an important place on our program. This is probably efficient, at least to a degree, in caring for the imbecile, but fails utterly with the insane. There are so many conditions, which are, so to speak, first cousins to the condition known as insanity, that segregation seems futile. Eugenics is a beautiful theory, but quite unsatisfactory practice. Then again the thing which we call insanity is so frequently what Billy Sunday used to call an end product or a finished product, that segregation cannot possibly reach it. The results, for instance, of syphilitic infection may not be manifest until the next generation. The processes reaching to the end product may be long or short. Then it may be that these conditions follow trauma, alcoholism, auto-intoxication and the puerperal state. Evidently segregation cannot reach these cases. "Humanity demands and duty agrees that no effort must be relaxed, and no means omitted to relieve the distress of the end products, yet another duty urges recognition and control of morbid processes which threaten an overwhelming sub-normal output." *Quo Vadis*—which the way? We may go on to the end of time treating cases of insanity and caring for those mentally diseased, and turn out many so-called cures, yet have progressed but little. This should not discourage us. The study of any complex problem requires much time and infinite patience, and it may be that

the cure of the mentally diseased will be a matter of evolution and the results of our labors show more clearly to succeeding generations. Why not in time a Sanatoxin? Some of our confrères insist that etiology is the important factor, others that pathology is a *sine qua non* to success, and others again that treatment, even though it be empyrical, is the desideratum. While in fact it is absolutely necessary before a rational treatment can be even begun that the etiology and pathology of any given case be thoroughly studied. We are inclined to the belief that the chief factors acting as *causes* are heredity, alcohol and drug habits. Now that prohibition has swept our land free from alcohol and the Harrison Act restrained the drug habit, maybe after the present generation of habitués of one sort or another hath passed away, and a clean new dawn hath appeared, that even heredity may be bound and shackled and the millennium may be coming on a chariot of gold, or to use a more modern figure, on a Wright biplane, or future generations may charge all ills and crimes to coffee and chewing gum. Eugenics promised so much and up to the present time has accomplished so little. The fact is the dignified science of Eugenics has been steeped in the mire of incompetency and has become the plaything of the public, and the unfortunate object of cheap wit from the stage and public press. Nothing kills so quickly as ridicule. The only way in which a statutory requirement for a clean bill of health may be made vital is that the parents take an active interest, and require that the young man asking for the daughter's hand, submit to these technical blood and spinal fluid examinations before gaining consent to the marriage. The more *law* you put into this thing now, the less education, and the results of this campaign depend not upon the law, but entirely upon education. For my part, I think the campaign of education is beginning to bear fruit in that more conscientious, keen, scientific men are devoting their researches to this particular subject. There has been a certain awakening of the public. These researches have been able to prove to the receptive public that certain penalties of syphilis, and drug habits have hereditary influences and do have direct bearing on the future health of our country. Our late war has taught us many things concerning the necessity of properly caring for the body. The local medical societies are doing wonderful work along this

line. We should enlist all our medical brothers in this great work of *preventing* mental disturbance and discourage mental freaks and idiosyncrasies. "The enlistment" says Dr. Smith, "of the medical profession in these activities brings into the cause the most potent and influential of all factors of prevention. The family physician, the one person who has the first and last word in shaping the destinies of the race, the one who dares walk where angels fear to tread, the one person who ventures within the sacred precincts of the hearth stone, or at the steps of the holy altar, makes bold to say 'thou shalt not.' Arm him with the facts being gathered to-day and the battle is half won."

Some hospital statistics show that one man in four and one woman in eight, admitted to the state hospitals for insane, have become mentally alienated because of an infection with syphilis. We all know of the frequency with which nervous tissues are involved following syphilitic infection. The state of Ohio, through its regularly organized health department, has inaugurated a campaign of instruction and established dispensaries where the disease may be treated free of charge to those unable to pay. This could, with profit be extended to the State Hospitals for those whose minds have begun to break under the strain.

These are some of the things which show the trend of our medical work to-day, and I am proud to say that our association is found in the van of this great army of enthusiastic workers.

Let us carry on.

MEDICAL AND ADMINISTRATIVE MANAGEMENT OF OHIO'S INSTITUTIONS.

By EMERSON A. NORTH, M. D., CINCINNATI, OHIO.

The General Assembly of the State of Ohio passed, on May 11, 1911, an act, to create a Board of Administration and repeal certain sections of the General Code. This Act, known as House Bill No. 146, was approved May 17, 1911, and the Board of Administration so created, became operative August 15, 1911. On this date, in accordance with Section 38 of this act, all boards of trustees, boards of managers and building commissions for the institutions named in Section 4 of said Act, were abolished. Longview Hospital, located at Cincinnati, being owned by Hamilton County, but maintained by the state, was especially named and provided for, by law, under Section 33. This institution still has a local board of directors who appoint the superintendent and control the expenditures of county funds.

"SEC. 33. The State shall continue to provide for the maintenance of Longview Hospital, and the Board in making estimates for the maintenance of the institutions under their control shall include a suitable amount therefor. Out of moneys appropriated for the maintenance of State Institutions, the Board shall apportion a proper allowance for said hospital. In all matters relating to the expenditure thereof, the Board shall have the same powers as in other like Institutions. In all other matters the Board of Directors of said Hospital shall continue to have and exercise the same power and duties now provided by law."

Previous to the passage of this Act each and every institution was managed and expenditures controlled by a local board of directors, managers or trustees, in accordance with sections in the general code, now repealed by this Act. Longview, however, was, and is, operating under a separate law known as the "Longview Hospital Act."

Under the old system of management, each institution seeking appropriation prepared its budget for the legislature. This natur-

ally led to a great deal of "lobbying" and political intrigue, which has been done away with under the present system. One budget is presented for the twenty institutions and each institution apportioned a sufficient amount by the Board of Administration, except in case of specific appropriations, as specified in the act.

SECTION 1. The intent and purpose of this Act are to provide humane and scientific treatment and care and the highest attainable degree of individual development for the dependent wards of the state;

To provide for the delinquent such wise conditions of modern education and training as will restore the largest possible portion of them to useful citizenship;

To promote the study of the causes of dependency and delinquency, and of mental, moral and physical defect, with a view to cure and ultimate prevention;

To secure, by uniform and systematic management, the highest attainable degree of economy in the administration of the state institutions consistent with the subjects in view;

This act shall be liberally construed to these ends.

SEC. 2. The Governor, by and with the advice of the Senate, shall appoint within ninety days after the passage of the Act, four persons, not more than two of whom shall belong to, or be affiliated with the same political party, to be known as "The Ohio Board of Administration," hereinafter designated as "the board."

They shall be selected so that the board will have as far as possible, in its membership the advantages arising from special study, knowledge or experience regarding the proper care and treatment to be afforded at institutions of the kind governed by it, the production, manufacture and purchase of articles required in or by such institutions, the care and cultivation of lands and the general principles and conduct of business management.

Their terms shall expire, respectively on the first day of February in the year 1913, 1914, 1915 and 1916. All appointments after the first shall be for four years.

SEC. 3. The governor shall have the power to remove any member for want of moral character, incompetency, neglect or breach of duty or malfeasance in office, the ground to be stated in writing after reasonable opportunity, to the member to be heard thereon. The governor shall on each removal report the same to the Senate with his reasons therefor, etc.

SEC. 4. Within thirty days after their appointment the members shall meet and organize; the member holding the shortest term shall act as president. They shall appoint a secretary, a fiscal supervisor and such other employes as may be deemed necessary for the efficient conduct of the

business, prescribe their titles and duties and fix the compensation, except as otherwise provided herein.

The board shall assume its duties on August 15, 1911, and shall have full power to manage and govern the following institutions: The Athens State Hospital, the Cleveland State Hospital, the Columbus State Hospital, the Dayton State Hospital, the Toledo State Hospital, the Lima State Hospital, the Massillon State Hospital, the Ohio Hospital for Epileptics, the Institution for Feeble-Minded Youth, which shall be known hereafter as The Institution for Feeble-Minded, the State School for the Deaf, the State School for the Blind, the Ohio Soldiers and Sailors Home, the Home of the Ohio Soldiers, Sailors, Marines, their wives, mothers and widows and Army Nurses, to be known hereafter as the Madison Home, the Boys Industrial School, the Girls Industrial Home, the Ohio State Reformatory, the Ohio Penitentiary, and the Ohio State Sanatorium.

SEC. 6. Unless decided to the contrary and the reasons therefor entered on record, the board shall hold at least one regular meeting each week at its office. Special meetings may be held elsewhere upon resolution of the board. At least once in each two months the board shall hold a meeting at the Ohio Penitentiary, the State Reformatory, the Boys Industrial School and the Girls Industrial Home, to consider paroles of inmates thereof, as provided by statute for such institutions respectively.

SEC. 11. Each of said institutions shall be under the executive control and management of a superintendent or other chief officer designated by the title peculiar to the institution, subject to the rules and regulations of the board and the provisions of this act. Such chief officer shall be appointed by the board, to serve for the term of four years, unless removed for want of moral character, incompetency, neglect of duty, or malfeasance, after opportunity to be heard.

The chief officer shall have entire executive charge of the institution for which he is appointed, except as otherwise provided herein. He shall select and appoint the necessary employes, but not more than ten per cent of the total number of officers and employes of any institution shall be appointed from the same County. He shall have the power to discharge them for cause, which shall be recorded in a book kept for such purpose, and a report of all appointments and resignations and discharges shall be filed with the board at the close of each month.

For reasons set forth in writing, the board may order the discharge of any employe of any institution, etc.

The board after conference with the managing officer of each institution shall determine the number of officers and employes to be appointed therein. It shall from time to time fix the salaries and wages to be paid at the various institutions, which shall be uniform, as far as possible, for like service, provided that the salaries of all officers shall be approved in writing to the governor.

SEC. 13. The board may assign among the correctional and penal institutions the industries to be carried on therein, having due regard to the location and convenience thereof with respect to other institutions to be supplied, to the machinery therein and the number and character of inmates.

SEC. 14. The board shall fix the prices at which all labor performed and all articles manufactured in said institutions shall be furnished to the state, or the political division and public institutions thereof, which shall be uniform to all and not higher than the usual market prices for like labor and articles.

SEC. 17. The board is empowered and required to purchase all supplies needed for the proper support and maintenance of said institutions, by competitive bidding under such rules as the board may adopt. All bids shall be publicly opened on the day and hour and at the place specified in the advertisement. The contract shall be awarded to the lowest responsible bidder, preference shall be given to bidders in localities wherein such institution is located, if the price is fair and reasonable and not greater than the usual price; but bids not meeting the specifications shall be rejected. The board may require such security as it may deem proper to accompany the bids and shall fix the security to be given by the contractor. It may reject any and all bids and secure new bids, if for any reason it is deemed for the best interest of the State to do so, but it may authorize the managing officer of any institution to purchase perishable goods and supplies for use in cases of emergency, in which cases the managing officer of the institution requiring the same shall testify such fact in writing and the board shall record the reasons for such purchase.

SEC. 31. Each managing officer shall before each session of the General Assembly, present to said fiscal supervisor an itemized list of appropriations desired for maintenance, repairs and improvements and special purposes, as he considers necessary for the period of time to be covered by appropriations. The fiscal supervisor shall tabulate such statements and present them to the board of administration with his recommendations. It shall then be the duty of the board to present the needs of the institution to the General Assembly. For this purpose a per capita allowance for the inmates, patients and pupils of each of the institutions shall be arrived at and a total allowance for maintenance asked for on the basis of actual number and estimated increase. Every special need shall be itemized and the appropriation asked for that specific purpose. The fiscal supervisor and the board shall furnish to the governor and to the General Assembly, such information as may be required regarding appropriations required. It is the intent and meaning of this section that all requests for appropriations for said institutions shall be placed under sole control of the board, and that appropriations for the maintenance and for ordinary repairs and improvements thereof, shall be made to the board in single sums to be asked for the several institutions according to varying needs.

Hereafter the appropriations for said institutions shall be of three classes: (1) Maintenance; (2) ordinary repairs and improvements; (3) Specific purposes.

Appropriations for specific purposes shall cover all items for construction, extraordinary repairs and purchase of land and shall be used only for the institutions and purposes specified therein.

There are 41 sections to the Act, but space will not permit a complete transcript here. The above sections give the salient points of operation. Other sections provide details, such as: salaries, residence of members, annual report, admission and discharge of patients, records, rules and regulations, bond of employes, employment of architects, report of accidental deaths, visits of the board, examination of buildings and grounds, warrants for salaries, power of board to investigate, reports to governor, etc.

On April 17, 1867, an Act was passed "in relation to the State Charitable and Correctional Institutions," but this Act was repealed February 10, 1872. A few years later however, April 3, 1876, another act was passed to establish a board of State Charities. Since the passage of this Act many changes and modifications have been made in the law, but the Board of State Charities, under the present law governing it, has a minor part in the management of Ohio's State Institutions. The principal duties of this board are those in connection with municipal jails, work-houses, infirmaries and children's homes as well as all institutions whether incorporated, private or otherwise, which receive and care for children. Under sections 1353, 1354, 1815, 1815-2, 1815-5, 1815-6, 1815-9 1815-12, the following provisions are made relative to the group of institutions coming under the management of the Board of Administration.

Plans for new buildings for State Institutions must be submitted to the Board. The Governor may order the Board of State Charities, or a committee of two members thereof, and investigate the management of a benevolent or correctional institution of the State. In committing patients to the insane hospitals, to the Ohio Hospital for Epileptics or to the Institution for Feeble-Minded, the Probate Judge shall certify to the superintendent of such Institution and the superintendent shall record the name and address of guardian, if any appointed, and of the relative or relatives liable for such person's support. The maximum rate for support as fixed by law is three dollars and fifty cents, but less amount may be accepted by the Board when conditions warrant such action. Release from payment or modification of payment may be made after an investigation by the Agent of said Board. It also specified persons liable for support and makes the County from which patients are sent liable for support of feeble-minded patients unless "provided the same is not paid otherwise as provided by this Act."

It has been argued, and with force, that the sections of this Act, herein specified, should have been included in the Act creating the Board of Administration and repealed in the Act governing the Board of State Charities. By so doing the Board of Administration would have the complete management of the twenty institutions specified in the Act.

The constitutionality of this Act, where it provides for a sum to be collected for support of patients, has been attacked on the grounds that it is double taxation. In a test case, however, the law was upheld. On the other hand in cases of long standing, where for the best interest of society and the patient the latter should have been kept in an institution, pressure has been brought to bear, because of the extra burden of expenses, by some relative, through habeas corpus or otherwise and the patient has been released.

At the last session of the legislature a special committee on re-organization was appointed and as yet no complete report has been made. We understand, however, there is some possibility that a recommendation will be made to the effect that the board now made up of four members be done away with and in its place be substituted one man as director or administrator.

It is maintained that it would be difficult to find any one person who would or could possess all of the qualifications to direct twenty institutions with such complex and diversified duties and responsibilities. Also that there would be a much greater opportunity for them to get back into and under the handicap of political influence, as was the case before the creation of the Board of Administration.

Under the present organization there are four members, two of each political faith. Mr. Guthery, President of the Board, is in charge of the farms and dairies, Mr. Riddle is in charge of the construction and manufacturing. Dr. Reinert is in charge of the medical work and Mr. Creamer is in charge of the institutional detail and paroles of the industrial schools.

In order that the work under the supervision of each of the four members be carried out to the highest degree of efficiency and economy and that the intent and purpose of the law be fulfilled, it was necessary to organize. Each of the departments were determined, filled and co-ordinated. The present operating

staff is made up of the following members: Four board members, one fiscal supervisor, one purchasing agent and one assistant, one executive clerk, one agriculturist, one horticulturist, one architect, consulting engineer, two draftsmen, tracer, two superintendents of construction, superintendent of prison construction, seven stenographers, eight clerks, one telephone operator and one messenger.

An inventory of June 30, 1919, shows the value of the institutions over which the Board has supervision to be \$27,828,725.94, which includes 11,153 acres of land valued at \$3,408,082.25 and buildings valued at \$19,652,034.32.

During the year 1919 the daily population of the twenty institutions was 22,651. The total operating expense to house, feed and clothe these wards was \$5,671,596.18, a per capita cost of \$250.39. The largest items of expense was food, \$1,624,755. Fuel \$659,221.57 and wearing apparel \$288,186.68.

Using the per capita cost of conducting the twenty institutions for the year 1911, the year previous to the organization of the Board of Administration, as a comparative estimate of cost under the old management and multiplying the difference each year by the daily average daily population during each year it is shown that in the eight years there has been an actual saving to the state of \$2,214,992.47. If we add 50 per cent to the per capita cost for the year 1911, the actual increase during the year 1919, and allow this difference in the comparison of relative cost for 1919, it is shown that there has been a saving of \$4,692,570.60 during the eight years of management under the Board of Administration.

This saving is not only shown in the process of adding, multiplying and subtracting figures in the form of dollars and cents, but is further shown in the form of development and increased efficiency. The latter can hardly be estimated in dollars and cents, but can only be expressed in terms of appreciation by the general public and managing officers.

The garden acreage has been increased from 1890 acres to 3314, showing an increase of 1424 acres. The total farm and garden production for the year 1919 was \$1,016,706.74. The total expense was \$559,016.48, leaving a profit of \$457,690.26 from this source.

To-day the institutions have 835 acres in lawns with 21,160 shade trees, 860 acres in garden and truck fields, 370 acres in orchards containing 25,145 fruit trees and 130,631 square feet of green house space. Several institutions have sufficient strawberry, raspberry and blackberry vines, currant and gooseberry bushes to supply their needs and over seven thousand bearing grape vines. Others are adding several acres of small fruit and berries this year.

The total value of live stock owned by the state is \$405,414.23, which includes 1021 milch cows, 236 heifers, 35 bulls, 112 calves, 458 horses and mules, and 3,939 hogs. Last spring a sale of registered Holstein cattle was held at Columbus and some very fancy prices were received for stock sold. It would be hard to estimate the value to the community and state at large in the distribution of this high grade stock to the stockmen of the state.

The development of the state-use system of manufacture at the penal institutions has resulted in the saving of large sums for the state and furnished useful, healthful and educational employment for the wards there confined. Under the provisions of the prisoners' compensation law, the dependents of the prisoners thus employed receive ninety per cent of the earnings allowed them under this provision. This in turn relieves the various local social charities of much responsibility and expense, as well as furnishing a decided help to those with too much pride to solicit aid from charity, and who do the best they can to make an honest living.

For the year 1919 the total resources from this department amounted to \$1,146,257.51. This does not take into consideration the saving to other departments and political subdivisions of the state and counties by purchases made through these agencies. There was a saving last year of many thousand dollars, to the auto license department through having them made at the penitentiary. Demands for greater production along many lines has resulted in plans for extension of industries at the Ohio penitentiary.

Because of the increased demand for raw material and labor, brought about by the world war, the past two years have been very difficult ones for improvements and betterments. During the past year, however, \$377,253.75 was expended for buildings and additions to old ones. Through the system of using prison

labor in the construction, under the supervision of a superintendent of construction has resulted in the most possible amount of improvement for the least possible expenditure. At Dayton a laundry building which had been largely destroyed by fire was rebuilt. At the Columbus State Hospital the old power house was, by extensive improvement converted into an industrial building. At the Custodial Farm the new power and industrial plant, started the year before, was completed. A new cold storage and bakery at the Ohio Hospital for Epileptics was started in 1919 and was about half completed by June 30, 1919. At Mansfield the new dining hall addition, started the year before, was completed. Cottages for inmates begun the year before were completed; one at Columbus; a receiving cottage at Massillon; two at Gallipolis; and three at the Custodial Farm for the Feeble-Minded. Three more cottages were begun at the Custodial Farm and are now completed. A cottage for one hundred patients at Gallipolis and one administration building and two cottages for the Bureau of Juvenile Research at Columbus were started and almost completed within the year.

The additions during the year provide accommodations for about 400 additional wards.

With few exceptions the architectural services for all buildings started during the past year and for most of those started during the previous year were rendered by that department. The total cost of architectural services for the \$410,000 worth of buildings was 1.39 per cent. This economy of cost with the saving through the purchasing department and through the services of the wards of the different institutions and prison, made the construction of these additions possible, under the conditions that have existed throughout the period of their construction.

In order that close co-operation be maintained between the members of the board and its various departments and the managing officers, and that subjects common to all might be presented and discussed, quarterly meetings are held at one of the institutions. The necessary expense incurred while attending such meetings are paid by the board out of funds for such purpose. At such a meeting held recently the president appointed a committee of three, consisting of managing officers of the insane hospitals, to develop plans to establish a mental hygiene society

for the state. At another meeting the president appointed a committee consisting of all the managing officers of the insane hospitals to investigate and determine the feasibility of a law for the unsexing of the mentally unfit. If in the opinion of the committee such law should be passed they were further instructed to prepare what in their opinion would be a safe, sane and practical bill for presentation to the legislature for passage. In view of the fact that there are many pros and cons to be considered in such an important question of social interest, no report has as yet been made.

The transactions of such meetings, papers read and discussed and other facts of general interest are published in the "Ohio State Institute Journal." This Journal is printed at the Ohio State Reformatory at Mansfield, under the direction of the Board of Administration and some two thousand copies sent to the institutions.

As has been the case in similar institutions all over the country, we have been sadly handicapped during the past two years in securing sufficient help. For two days early in the war when the army was making every effort to complete its medical staff, the writer was the only physician in our hospital; withal, however, during the past year 3778 Wassermann tests were made in the various laboratories out of which number 984 showed positive reactions. In addition to this much good advice and treatment has been given to relatives of patients showing positive reactions. In some localities we have been able to develop clinics where such patrons of the institutions can be sent for treatment and advice as the case may indicate after thorough and careful examination. This is easiest of accomplishment in the larger cities particularly where a medical college is in existence, yet in the more rural districts like Athens, they have done much for their patrons at the institutions by making blood examinations, directing treatment and giving advice how to care for themselves and other members of the family. At Cincinnati we have a mental hygiene clinic in connection with the medical department of the university, where all discharged patients and patients out on trial visits from Longview are referred for the purpose of following up and keeping in touch with. We are also happy to say that we have succeeded in interesting the various social agencies to the point of

very efficient co-operation. We are developing psychiatric nursing through such agencies. In other words, we are making "haste slowly" by feeling our way in a new field of endeavor. It shall be our aim to finally associate all the work of similar nature under the direction of one psychiatric nurse or head. At the present we have a system of having visits made to the homes of patients on trial visit from Longview. These visits are made under the direction of a worker from the Associated Charities. This worker is given a list of questions with a brief history of the case by the superintendent and the worker in turn reports weekly, monthly, or as often as the case demands to the superintendent. After these reports are made the cases are discussed, the frequency of home visits and any changes in line of procedure or treatment determined. If it is found that the patient is failing to readjust after all methods of readjustment have failed, or being at large is a detriment to the patient or some member of the family, they are returned to the hospital. At the end of the trial visit period if the patient seems perfectly well they are discharged; if they are found to be getting along under home conditions with the advice and assistance of the worker, the period of trial visit is extended until a reasonable time has elapsed when they return to the hospital for final discharge. No patient on trial visit is discharged until they have returned to the hospital for final staff or superintendent's action.

It is our purpose to assist in the readjustment of these unfortunates after they leave the institution and at the same time make sure that the home or some member of it is not being handicapped by the patient upon his return. We have found that a mother's love often causes her to seriously handicap other children in her family in order that her poor mentally deformed child be cared for at home and not sent back to the hospital. We also believe if these homes are entered by the proper persons in the right manner much reeducation can be done and propaganda begun among the class where the most good can be accomplished for the methods that must come in the future, toward preventing feeble-mindedness, epilepsy, certain forms of insanity and degeneracy.

During the past year 6139 minor and 165 major operations were performed.

The institutions without dental equipment were each appropriated \$500 for such purpose. The Board now is considering ways and means for securing competent dentists to perform this work. It is their purpose to divide the state into four sections and place one dentist in charge of the work of the institutions in each section.

The epidemic of influenza which swept over the country during the winter of 1918 and 1919 did not spare the institutions of Ohio. Cases were reported from seventeen institutions. There a total of 4040 cases of influenza and pneumonia of which number 3650 were inmates and 390 officers and employes. There were 248 deaths from this cause, 228 of inmates and 20 of officers and employes.

Because of the scarcity of nurses and attendants in the institutions at the time on account of the demands of the war and the number of employes sick, the Board detailed inmates from the penitentiary and the Ohio Reformatory for Women to assist at the Boys' Industrial School, Ohio Hospital for Epileptics and the Lima State Hospital. These inmates rendered noble and efficient service.

At Longview we now have plans in the hands of the architect for a new psychopathic building or receiving cottage for both men and women, the estimated cost of which is about \$400,000.

When this building is completed it shall be our purpose to divide our institution into three main departments: (1) Receiving department; (2) custodial department; (3) re-educational or occupational department.

All patients will be received at the receiving cottage into a suite of rooms constructed for such purpose. While in such rooms each patient will be bathed, examined and classified by the physician in charge. Patients obviously custodial in type, for example, senile dementia, shall be transferred to wards designated for such type cases as soon as examination is completed. All other patients, particularly where there is any doubt as to proper classification, will be kept in this building and such treatment prescribed as may be advised, until such time has elapsed that a definite diagnosis and prognosis may be determined.

We hope to give every patient admitted to our institution all of the advantages of up-to-date and scientific treatment under

the direction of sufficient and competent help and at the same time prevent the psychopath and recoverable cases from coming into contact with the sad and most unfortunate side necessary in every institution of such character.

This building will be two stories high and divided in the center, thus making one-half for men and one-half for women. We want to emphasize the fact that the division will be distinct and that there will be no part of the building in common, except the hydrotherapy room. Here certain days and hours will be designated for treatments so that the men and women patients at no time will come into contact with each other.

In it provision is made for receiving rooms, isolation rooms, laboratory, dental room, hydrotherapy rooms and occupational rooms. The food for all the patients will be prepared in one kitchen where arrangements will be made for special diets. We feel that this building will fill a long felt need in the building group of our institution.

Perhaps no state has made more advance toward the reclaiming of juvenile delinquents than has the state of Ohio through her Bureau of Juvenile Research, under the direction of Henry H. Goddard. This bureau was established in May, 1918. You will hear further of this department from Mr. Goddard.

We realize that with possibly few exceptions, all of the institutions of Ohio are overcrowded and that the ratio of employes to patients has been out of proportion, but when we consider the conditions that have existed all over the country for the past two years, we feel justified in saying that the management of Ohio institutions under the Board of Administration has been both efficient and economic. The future success or failure of a board of such character must depend upon the type of men appointed to its membership by the governor.

DISCUSSION.

DR. CHAS. H. CLARK.—Dr. North in his paper has explained in a thorough manner the operations of the state institutions in Ohio under the management of the Ohio Board of Administration and in my discussion of his paper I doubt whether I can add very much on the subject.

The management of Ohio hospitals under the existing law has been in operation sufficiently long for us to form an opinion as to whether or not it is an improvement over the old system of management by a separate

board of trustees for each institution. The present plan has passed beyond the experimental stage and the managing officials are heartily in favor of the present system, and would, under no consideration, care to go back to the old system of boards of trustees. There are 21 institutions under the management of the board which are designated as follows: Hospitals for the insane, penal and reformatory institutions, and educational institutions. (State school for the blind and state school for the deaf.)

The board has established a central purchasing department which has at its disposal large warehouses located at the Ohio Penitentiary in Columbus, Ohio. This department buys direct from the manufacturer and producer, thus eliminating the profit made by the middleman, and it is also able to take advantage of the market and buy in large quantities from time to time, and store the commodities in the central warehouse for future distribution to the different institutions as they requisition for supplies. This system of buying has resulted in an enormous saving to the state, for example—the board laid in a large supply of sugar at the very low cost of 11 cents a pound, and this particular article advanced during the year to between 25 and 30 cents a pound, wholesale.

The personnel of the board is well taken care of in the statute, which requires one member to be a theoretical and practical engineer who has general supervision of all the various power plants in connection with state institutions. His recommendations regarding various improvements have been the means of bringing these plants up to a most efficient basis and his advice is constantly being sought by the various managing officials.

Another member is a practical farmer and in this division of the work he has an efficient organization consisting of an expert agriculturist and horticulturist. These men visit the various institutions at frequent intervals and they outline the work in each institution and all of the state institution farms and gardens are now managed in a scientific and proper manner. The soils have been tested and crops are grown which are suitable for each particular soil on the farms.

Another member is a representative business man and his particular duties are in connection with the purchasing department of the board.

The fourth and last member is a physician. Naturally the most important part of the work in connection with our state hospitals is the care and treatment of patients committed to our institutions. We have frequent consultations with the medical member of the board regarding the treatment of patients committed to our hospitals and at the present time an intensive campaign for the eradication of syphilis is being carried on. All patients admitted to our hospitals are given a blood Wassermann test and if found to be positive, the treatment is instituted at once and continued until the disease is either eradicated, improved, or the individual rendered non-infective.

All of our hospitals received an appropriation for dental equipment which was recommended by the medical member of the board and this equipment is being rapidly installed in each institution. The state will be divided

into districts and skilled dentists will be employed for each district. A thorough dental examination will be given each patient and where diseased processes are found they will be corrected.

Most of our institutions have modern hydrotherapy equipment but a few of them are still without the facilities for carrying out this particular line of treatment. However, the medical member of the board has requested appropriation to be made to install this equipment in all of our hospitals.

Under the management of the board of administration the Ohio institutions are absolutely out of politics and I have never known them to be so free from politics as they are at the present time.

DR. ALBERT ANDERSON.—I want to inquire whether this board controls all the institutions of the state—state prison, as well as state hospital, educational, etc.? I was impressed with the expert management, and I would like to know if these experts are employed by the board for these various kinds of work.

DR. KILBOURNE.—I was very much interested in this paper. I was at New Orleans at the meeting of the American Medical Association and listened to an address by the governor-elect of Louisiana, which consisted of an excellent program he had outlined for the improvement and management of the state institutions, and I congratulated myself that I lived in Minnesota. The method of government that emanates from a new governor-elect is a wonderful thing, and it is very interesting to note what different ideas come from those sources and it is also interesting to note that the general success is about the same. One thing that interested me was the harmony that existed between the medical member of the board and the superintendent.

I want to emphasize the fact that every state that has an organization, has the best organization of any state in the union, and I congratulate Ohio on its excellent showing. I know they have a good system and should be proud of it.

DR. S. W. HAMILTON.—I want to ask a question: can those who are close to the Ohio system state whether there is any tendency toward difficulty in getting decisive action from a board that consists of an even number of members? Further, has this board found it possible to raise the standards of wages, etc., in proportion to the increasing cost of living in the past three or four years?

DR. NORTH.—All of the institutions of the state, insane, feeble-minded, penal, correctional, industrial and the tubercular sanatorium are under the board of administration.

The heads of the different departments of the board are hired by the board and paid by the state out of funds allowed for the running expenses of the board.

My reason for using figures in the paper was not to compare Ohio with any other state, but simply to compare two different systems used in our

state. We have operated under two distinct systems in the past and I believe all of the managing officers of the state will agree with me in saying that the present system under the board of administration is far superior to the old system under local boards of directors, etc. I also believe that the present members of the board are broad minded men who will agree with me in saying that the economic and efficient management of each institution depends to a very large degree upon the superintendent and his cooperation.

In answer to the other questions asked, I might say that my experience has been most pleasant and in matters of business or finance I have always received very prompt action. During the last two years when dollars were scarce and hard to get and when all institutions have run from fifty to one hundred thousand dollars over their appropriations, I have received sufficient funds for our necessary wants.

THE RESPONSIBILITY OF THE PUBLIC IN RELATION TO STATE MEDICAL INSTITUTIONS.

By WILLIAM H. PRITCHARD, M. D.,
Columbus State Hospital, Columbus, Ohio.

Ohio has been signally honored in having been chosen as the present meeting place of this national organization, and it therefore seems meet that we who labor in this commonwealth should frankly and truthfully lay before this association both the advantages and the difficulties under which we work. The purpose of this paper is to discuss the fiscal system of the state as it applies to state medical institutions, and to seek in a feeble way to arouse a greater degree of public interest in their welfare.

In Ohio we are wrestling with a taxation puzzle, which is the result of tangled legislation. On the one hand bitter complaint is made by tax-payers of the burden under which they are alleged to be staggering, and on the other hand all the administrative units, both local and state, are asking for more money. The blame for these conditions is commonly placed on the shoulders of distributors of public money, contemptuously styled "tax spenders," and popular indeed is the political writer who can most effectively inveigle against the alleged extravagances of public officials. Meanwhile, bonded indebtedness in local communities is piling up, and the tax rate must be steadily increased to take care of interest and sinking fund charges. There is, no doubt, much re-duplication of effort and much unnecessary expenditure of money in many of the state departments and bureaus, but this criticism is not generally made regarding the state institutions. In fact, I think it will be generally admitted that in these institutions every dollar is made to go as far as possible. The State Bureau of Inspection and Accounting has uniformly given them a clean bill in reference to expenditures of public money.

The complaint that the burden of taxation is unequally distributed is undoubtedly well grounded. In Ohio the Constitution

provides that real estate on the one hand, and all forms of personal property including money, stocks and bonds, as well as live stock, merchandise, household goods and personal belongings of every description on the other hand, shall be *uniformly* taxed at their true value in money. Note the word *uniformly*. In practice this provision is honored principally in the breach. It is conservatively estimated that the value of personal property represents rather more than half the wealth of the state, yet real estate which cannot be well concealed bears 60 per cent of the burden of taxation, while personal property, much of which can be readily concealed, bears but 40 per cent of the load.

An extended discussion of the general subject of taxation is perhaps out of place in a meeting such as this; yet, physicians have ever been leaders of thought, and this subject is the very cornerstone of the whole fabric of our civilization. For forty centuries before the time of the first Roman Emperor, when "there went out a decree from Cæsar Augustus that all the world should be taxed," this problem had vexed mankind. From the proceeds of taxation were builded the pyramids of Egypt, the hanging gardens of Babylon, the temples of Greece, and the coliseum at Rome. By taxation stable government was established in Europe in place of the chaos of the Dark Ages. Through taxation liberty was guaranteed our British forefathers in the Magna Charta. On a certain night in Boston harbor our own independent history began with a tea party, which grew out of the question of taxation. As we face the problems of to-day we are prone to think that they are new problems, yet many classics in ancient and modern literature deal most understandingly with the problems of taxation. The Mosaic law, given forth on Mt. Sinai more than 3000 years ago, proclaimed a system of taxation based upon justice and equity—an equalization of the burden of taxation according to the individual's ability to pay—a tithing system—the first income tax—which well might serve as part of the model for a taxing system for to-day. Plato discoursed learnedly on taxation based on justice to all. Lord Bacon and Sir Thomas More in their Utopian conceptions of an ideal state did likewise. In more modern times Alexander Hamilton, Adam Smith, De Tocqueville and John Stuart Mill have

laid down precepts and fundamental principles of taxation which might very profitably be studied by the harassed statesmen of the present time.

The psychology of the tax-payer is a peculiar thing. Men will squander their money without a thought in riotous living, or in the pursuit of pleasures which are fleeting. They will thoughtlessly purchase all manner of useless and undesirable merchandise. They will give freely to charity or contribute lavishly to some form of propaganda which profits them nothing. They will stoically lose large sums at a gaming table. They will pay their self-incurred debts without a thought of defrauding the creditor, but when confronted with a tax return blank they will practice every sort of evasion possible, including downright lying, in order to avoid contributing a just proportion of their wealth to the purchase of the most important commodity which money can buy, viz.: good government and the righteous discharge of the civic obligations which men owe to each other. From the very beginnings of human history, even from the remote age when the "herd instinct" first began to manifest itself a community of interest has demanded that men make certain personal sacrifices of service and of money for the common good. Money paid as taxes into the common treasury, if expended with even an approach to discretion and honesty, under a representative form of government, insures a degree of protection against fraud and violence and an opportunity for individual and civic development which is indispensable, and which transcends in value any other commodity or service or condition of living which money can procure.

The state hospitals are, however, not directly interested in local taxing problems. Very few citizens have knowledge of the fact that none of the money raised by taxes levied on real estate and personal property is used by the state government for general governmental purposes, or for the support of the state institutions. All of such taxes are used for local purposes only—viz.: For defraying the expenses of villages, cities, townships and counties and for maintaining the public schools. In Ohio the state collects no local taxes, except that a certain percentage of the local levies for school and road purposes are collected by the

state and re-distributed to local school districts and road districts on the basis of their needs.

As a state Ohio has no public debt and is prohibited by the constitution from incurring any bonded indebtedness. All of her income, which amounts to more than \$25,000,000 per year, comes from special taxes, as follows:

	Per cent.
Taxes levied on capital and earnings of business corporations....	43
Liquor and cigarette taxes	12
Automobile registration fees	9
Interest, rents and permits, U. S. Government aid to roads and schools, sales of materials, state fair receipts, inheritance taxes and departmental service fees	21
From local taxing districts, to be re-distributed to needy school and road districts	15
This income is expended as follows:	
For schools and universities	30
(This is twice the amount received from local taxing districts for school purposes.)	
For road building and state aid to counties for roads.....	15
For agricultural purposes	5
For general state government purposes	17
For benevolent, correctional and penal institutions.....	33

One-third of the state's income is expended for the public institutions of the state and yet it is not enough. Our institutions have many urgent needs that cannot be supplied from the usual appropriations.

Someone has said that "because nations—that is men *en masse*—tend to stupidity mankind moves slowly, but because individuals have a capacity for better things it moves surely." Since neolithic times mankind has been moving slowly but surely forward, progress being due primarily to the presence in each generation of individuals who have this capacity for better things. We live in the present, but we draw our lessons from the past. Time was when the insane, the epileptic, the idiot and the feeble-minded criminal were outcasts; shunned of all men, either feared or despised as being possessed of devils. For centuries they were thrown into dungeons to die of starvation and neglect, or perhaps chained to the floor or wall in some dismal prison. Two generations ago it was sufficient if they were housed in reasonable comfort and given food and raiment. The requirements of a

later day included a modicum of medical attention, somewhat more individual liberty, and the beginnings of an understanding of the pathogenesis of disease. To-day all forward looking individuals insist upon comprehensive investigation of sociological and psychological undercurrents and tendencies and the application of modern methods in the study and treatment of mental disorders, mental deficiencies and perversions.

To secure these ends greater and still greater facilities in the way of workers and equipment are required and more and more public money must be made available. Since in the end the result will undoubtedly be favorable to the race the end should justify the means, and persistent efforts must be made to mould public opinion to this view. The public must be compelled to see its own interest and having seen it require its representatives in legislative halls to heed the call of those who know whereof they speak.

It is quite the fashion to place the blame for insufficient appropriation wholly upon legislative bodies. This is largely unjust for two reasons. In the first place the state, by reason of a constitutional provision prohibiting the issuance of bonds or the incurrence of debt in any form, must of necessity live within its income, and legislatures must therefore limit their appropriations to the sum total of the state revenues. In the second place, and this is the most important reason, legislators are only the representatives of their constituents. In the concrete, they represent the preponderance of the public sentiment of the commonwealth. Importuned on every hand for greater appropriations, hampered by the limitations to the income of the state, fearing, as the average man fears, to lay further burdens upon the public in order to produce more revenue, they take the path of least resistance and pursue the course that will offend the fewest people.

De Tocqueville, in his admirable analysis of American characteristics, speaks of what he calls "the doctrine of public interest rightly understood." Writing of Americans in contrast to the peoples of Western Europe, he says they "are fond of explaining almost all the actions of their lives by the principle of interest rightly understood: they show with complacency how an enlightened regard for themselves constantly prompts them to assist each other and inclines them willingly to sacrifice a portion of

their time and property to the welfare of the state." And again, "The American moralists do not profess that men ought to sacrifice themselves for their fellow creatures because it is noble to make such sacrifices; but they boldly aver that such sacrifices are as necessary to him who imposes them upon himself as to him for whose sake they are made." (P. 130, Vol. 2.)

These observations were made three-quarters of a century ago. To the enthusiastic Frenchman accustomed to the sordid selfishness of European peoples the buoyant idealism of the young republic made a strong appeal, and he gave our people credit for a greater degree of public spirit than they perhaps deserved. To us who are in daily contact with the difficult situations which arise from the public's failure to recognize the facts which pertain to its best interest, his philosophy appears unduly optimistic.

As regards the inner conscience of the American people his conclusions are still doubtless correct. The war has conclusively shown the extent to which the American citizen is willing, when sufficiently aroused, to place himself and his goods upon the altar of his country. The problem now is to show this same patriotic citizen that the welfare of the state in times of peace demands sacrifices also, not so spectacular, but none the less insistent. In the war against Germany we freely gave millions of dollars to stay the hand of death on the battlefields. In the conflict with tuberculosis, with cancer, with venereal diseases, with mental disorders, with epilepsy and feeble-mindedness and with crime, we are lacking as a people in a realization of the tenfold more deadly nature of the enemy, the greater number of the victims, and the greater menace to our civilization.

Our public hospitals are the result of the partial recognition by the public of its obligations. This recognition is only partial; non-existent in some communities, vaguely apparent in most states and communities and frankly admitted in very few.

Native Americans are prone to boast of their common heritage of political and religious freedom and of equal opportunity in the race of life. If we accept the principle of Mendelian inheritance, we must also accept the doctrine that the characteristics of our forefathers which led them to brave the perils of an unknown sea, and establish colonies on a savage continent, in which new principles of government should obtain, have been transmitted to

their offspring. At the time of the American Revolution there were approximately 3,000,000 inhabitants in the British colonies which rebelled. With little exception they were of the same mind, dominated by the same ideas of government. Otherwise, how could they within a period of 13 years—1776 to 1789—have carried to a successful issue a war with Great Britain, and have established without prolonged internal strife a constitutional government which in a century and a quarter has grown to be the dominant power of the world? There was present in the germ plasm of these people something that had not hitherto been present in the germ plasm of such a mass of people at one time. Their descendents now number more than 30 times 3,000,000 people, but they have the same impulses and are dominated by the same ideas as their forefathers. Can we doubt that these characteristics have been preserved in any way except by their transmission through the germ plasm of the race?

Claiming therefore full credit for our inheritance of the virtues of our forefathers, must we not also assume equal responsibility for their faults? These also have been transmitted through the germ plasm of the race. Must we not willingly assume the burdens that have come to us from these same forefathers because of their rôle as unwitting hosts of the spirochete, the gonococcus, and the germs of tuberculosis and cancer; as misguided sponsors for alcohol and all its ravages; as ignorant upholders of the right of men to make unholy and unsuitable marriages and beget myriads of weakling children? These also are the common heritage of the race. Whether or not it can be authentically traced, the lineage of a very large majority of the people of America goes back to founders of this republic. Their blood is our blood; their virtues are our virtues, and for their vices we must make amends.

We hear a great deal in these days concerning charitable enterprises—private charity—civic and state charity. The sentiment is misnamed. Justice is the word. There is no charity, public or private. He who gives of his time or substance to better the lot of his fellow creatures is merely fulfilling the demands of simple justice; merely doing his bit to correct the faults of his forefathers; merely pruning in the garden of humanity that the future crop may be better men.

In Ohio institutions we lack many means for the production of this better crop of men. We lack means for the employment of sufficient physicians, research and laboratory workers and dentists. We lack means for the employment of teachers in the fields of industrial and recreational therapy. We lack means for the employment of social workers in the after care of patients and in conducting out-patient clinics. We lack means for the purchase of sufficient medical and surgical and laboratory equipment and supplies. We lack the means of employing high class nurses and attendants in our wards. We lack the means for constructing sufficient buildings of suitable character for the various purposes of institution care. We lack the full cooperation of the courts in dealing with the problem of mental disorder, feeble-mindedness and crime. But above all and underlying all these handicaps, we lack the public appreciation of the menacing nature of these problems and its intelligent support in solving them.

As a means to their solution it should be emphasized that haphazard methods of making appropriations should be forsaken and a settled policy for providing funds for our state institutions should be devised. The public needs more information concerning their requirements than is given it in the press notices of proposed appropriations by a finance committee of the legislature. Ample provision for their needs is a fundamental duty of the state—as fundamental in fact as the duty of providing every normal boy and girl with an education that will fit them for a useful life. In both these fundamental obligations of the public there is lamentable failure to provide the necessary funds. Money for the support of schools is raised by setting aside a definite proportion of local tax levies. School buildings are provided for by the issuance of bonds which must be authorized by a vote of the people of the school district. None of the school districts of the state have sufficient revenue. Teachers are underpaid and bonded indebtedness is rapidly piling up. The remedy lies in changes in the constitution which will abolish the nefarious so-called uniform rule, fix a definite limit to the extent to which real estate may be taxed, permit of classification of all other property for taxation purposes according to its ability to earn income, and remove exemptions from taxation now granted certain forms of securities, which are usually producers of good

incomes. In the words of Ohio's very capable state auditor such a change in the constitution "would make an income tax certain of enactment, easy of enforcement and just in operation. An equitable income tax is the best and fairest system of taxation that has ever been devised. *The normal source of taxation is income.*"

I have reverted to the question of local taxation, which as before stated does not directly concern us, for the reason that its just solution along the lines suggested also makes easy the solution of the problem of revenues for our state institutions. If the local taxing problems can be rationally solved by compelling hidden income producing property to pay its just share of revenue, the local school districts will have ample funds for all legitimate purposes and the state will be released from the obligation of giving state aid to the common schools. There need be no school districts in Ohio which require state aid if hidden personal property can be compelled to bear its just share of local taxation.

The state in 1920 will distribute to the local school districts more than \$2,800,000. Of this sum less than half a million dollars will be collected by the state from local districts to be re-distributed to needy schools. The balance of over \$2,300,000 will be taken from the general revenue fund of the state. Consider how well the state institutions could use this \$2,300,000 or any considerable part thereof to supplement their present appropriations. Their utmost requirements in the way of more and better paid physicians, teachers, social workers, nurses and attendants, and their utmost requirements in the way of medical equipment and supplies of every kind could be supplied for less than half that sum.

This \$2,800,000 is distributed to all the school districts of the state on the basis of two dollars per year for every child of school age. In 1919 there were upwards of 1,400,000 such children in Ohio.

Does any one suppose that if the owners of personal property in these school districts were paying their just proportion of the local school taxes, the sum realized would not be many times the sum of two dollars for each child enrolled in these school districts?

The revenues of the state government come from sources from which there is no complaint. For general government purposes, including the support of the state institutions, the revenues come from franchise and excise taxes on corporations, the interest on state money deposited in banks and from the inheritance tax. For the support of the state agricultural department and the building of state roads, money is available from rents and permits, sales of material, state fair receipts, automobile license fees and from the United States Government. The various bureaus and commissions get their support from fees and receipts from the furnishing of required licenses and permits. For the support of state colleges, universities and normal schools there are available endowment funds accumulated from the sale of public lands, and a state tax levy which would be amply sufficient if personal property throughout the state paid its just proportion of local taxes. Revenues from these various sources are not kept separate, but with some exceptions are all passed into the general revenue fund of the state, where they are subject to draft by the legislature. These are all legitimate sources of state revenue and are ample for legitimate state purposes. The excise tax on liquor has been abolished by national prohibition, but this loss is perhaps a distinct gain, and will be largely compensated by increased automobile license fees. There is no occasion for disturbing the legislation under which the revenues of the state are raised. All that is necessary for the proper adjustment of all our public financial troubles is the serious appreciation by local tax payers of their civic obligations, in order that the state government may be relieved of the necessity of vicariously atoning for their sins.

Concretely stated, this means the public approval of changes in the constitution which will relieve the excessive burden of taxation borne by real estate, and will permit of the enactment of legislation which will uncover the great mass of credits and income producing personal property which now escapes taxation.

Our government is a government of the people, by the people, for the people, and its ultimate destiny will be determined by the fidelity with which its people adhere to the principles of this famous aphorism of Lincoln.

DISCUSSION.

DR. COPP.—I wonder why we do not get money for these purposes! The trouble does not lie in laws of taxation. I believe we do not get the money because we do not convince the legislature and the public that we need money for a purpose worth while to serve. I have been tremendously impressed with the fine program of efficient administration in Ohio. I have been convinced that this organization has spent less money than former organizations. Now that is good so far as it goes, but I want to know what results were accomplished by this organization? Did they equal or exceed the standards of care or accomplishment of the old organizations? Further, did the old organization fulfill its duty toward all the important human factors involved? If not, what credit is there in saving money over that régime and leaving essential work undone? What is all this economy, this fine administration, all this saving for? Is it simply to have more money in the state treasury, to make a fine showing for ourselves and fail to keep up standards? Ought we not to save money by good administration to have more money to spend for our patients' welfare? These institutions have no right to exist if they are not doing the work which they were created to do. This is a session on administration and we expect business to be talked, but I think another reason why we don't get money is because we don't talk the human side of our problems—doing things for our patients. Suppose by spending more money we could, by prevention or better treatment, succeed in diminishing the number of these patients. Wouldn't that be true economy?

DR. ALBERT EVANS.—Restating the question put by the reader: How does Massachusetts manage to get something that Ohio cannot procure? In Massachusetts the care of the insane, the feeble-minded and the epileptic is held to be so big a problem as to require the undivided attention and untrammelled action of *experts in their care*. These patients are in hospitals, not primarily for discipline, but for treatment. This so-called board of control, having to do with problems clearly dissociated, it would be interesting to inquire: what are its reactions when faced with the question of procuring appropriations for *Medical Research*?

Massachusetts is thus far enlightened, that it would be difficult beyond the possibility of success, for a board of control to become there established. As it now is, with its commission on mental diseases, having as its director an expert in the institutional care of the insane, feeble-minded and epileptic, legislative attention respects and becomes fixed upon the purely humanitarian and scientific aspect of all problems of essential appropriations.

DR. PRITCHARD.—In reference to Dr. Copp's remarks we have the reputation of having pretty fair institutions in Ohio although we do lack some facilities that some other states seem to have. Ohio does not seem to have sufficient revenue to give us these. The state's expenditures for 1920 will exceed its revenue. If expenditures for local purposes were taken care

of, as they should be, by an adequate local taxing system the state would have ample funds for all its legitimate purposes.

I was in hopes that some one would tell us how Massachusetts gets revenue enough to serve all her purposes. We cannot do that here in Ohio. We somehow have not found the right method of arousing popular interest, although, whenever our institutions are spoken of, they are well spoken of. I think many other states have to face the same problems that confront us in Ohio. We simply hope for better things and do the best we can.

DR. COPP.—I hope no one may think I have the feeling that Ohio is not doing as well as anybody else. I think this is the general situation everywhere.

THE PROBLEM OF THE PSYCHOPATHIC CHILD.

By HENRY H. GODDARD,

Director Bureau Juvenile Research, Columbus, Ohio.

The recognition of psychopathy among children marks a great step forward in both preventive medicine and in practical sociology. Our slowness in recognizing the condition would seem to be due partly to a false theology and partly to the fact that man in his study of man has almost always begun with the full grown adult with all the complexities of the fully developed organism.

Of course, adult insanity was long regarded as demon possession and largely beyond the reach of medical science. Small wonder then that child insanity should be overlooked.

But add to this the theological dogma of original sin and we have a complete *alibi*.

The argument would run somewhat as follows: Mental disease is shown largely by strange behavior of the person affected, but children manifest no strange behavior except such as is easily accounted for by the inherent wickedness of man. Gradually, however, defunct theological dogmas are being buried and at last we are beginning to ask for a *natural* cause of peculiar child conduct.

The answer, as yet hardly more than whispered, is that *much of juvenile misbehavior is as surely due, to a brain functioning badly on account of disease*, as is similar conduct in adult.

In 1909, while making mental tests on the feeble-minded at Laconia, New Hampshire, an assistant from the Vineland laboratory was asked by the superintendent to come to the Concord Asylum for the Insane to test a group of patients concerning whose insanity there was some doubt.

The tests showed low mentality and helped to solve some difficult problems.

This seems to be the first time standardized tests were used on the insane.

An analysis of these tests showed peculiarities that have proved characteristic of the insane. Whereas the normal child or the

feeble-minded reaches his level by answering all the questions as they come, up to almost his final stopping point, the insane *scatter*, i. e., their failures are scattered through several years and are found side by side with the successes.

In 1910, Kent and Rosanoff published their "Study of Association in Insanity." In this they showed—what psychologists knew in theory—that association of ideas as well as association times constitutes an exceedingly delicate indication of mental functioning.

Moreover, Kent and Rosanoff gave us norms so that we now know what is abnormal mental functioning—within limits. It is by the use of these two procedures with several others that we at the Ohio Bureau of Juvenile Research have been for two years detecting juvenile psychopaths.

PROCEDURE.

When a child is admitted he is at once given the association test and his performance is scored. He is next given the Binet and other tests such as Healy and Porteus.

The following points in standardization have been worked out by Dr. Florence Mateer of the Bureau:

"Laboratory Findings.—On the mental tests relative to other things that they do, these children are comparatively poorer in memory for digits, lifted weights, copying the design, sixty words in three minutes, disconnected sentences and usage of language which is superficial and which seems to be always giving an answer which would score on the tests until it is analyzed carefully, when one finds that it goes all around the point but misses the vital and significant thing. The actual mental age obtained is usually the result of scattering over a wide range of years with a comparatively low basal year. The performance tests done by these children are frequently indicative of a far lower level than their mental age would indicate. The opposite of this is true with feeble-minded children. The psychopaths are especially apt to fail on the adaptation test and on the Healy Pictorial Completion. They do spectacularly poor work on the Porteus tests. They frequently are very poorly oriented but are very much better in

general information than feeble-minded children. Most marked indication of their abnormalities is found on the Kent-Rosanoff Association Test, on which they give a curve showing a high frequency of individual reactions.

The following 10 points are considered as bearing on the question of psychopathy:

1. Range above basal on Binet (Stanford Revision) more than four years.
2. Distribution on Stanford.
3. Quality of individual test responses on Stanford.
4. Association tests, more than 10 individual reactions.
5. Association tests, quality of response.
6. Lack of balance in performance tests, more than four years.
7. Orientation, very poor or very good.
8. School work, above actual level.
9. Incoherence, etc., in own story.
10. Behavior during examination.

These may need some explanation.

1. The range of tests on the Stanford means the number of years through which the child is able to do tests above his basal year; for instance, a child may have a basal year of 7 and have nothing above the 12th year except the design in the 18th year, yet this range will be 18 minus 7 or 11 years. All children have some range above basal, but an inspection of cases has led us to assume more than 4 years above basal year as an indication of psychopathy.

2. The distribution on Stanford may be significant aside from the range of distribution; that is, a child may fail on tests which definitely indicate instability or which definitely indicate mental defect. Thus a psychopath is apt to be poor in memory, in association and in the weights, while he is apt to be good in comprehension and reasoning. The feeble-minded child is apt to have a rote memory ability many years above any other ability.

3. The quality of the individual test responses on the Stanford is also significant. The psychopath gives peculiar and individual reactions instead of those which one would expect. He is apt to fall into the use of nonsense syllables when giving 60 words in three minutes. He interpolates peculiar things in reading. He

uses many-syllabled words in the places where the ordinary child uses simple words. His reaction time may be accelerated or retarded.

4. If a child gives more than 10 individual reactions on the association test or if he gives more than 45 most common associations and has in the latter instance a normal mental age, this may be taken as an indication of psychopathy.

5. When the analyzed association test is studied for quality, the test may be counted psychopathic if more than 10 reactions are found which are abnormal according to the Kent-Rosanoff definition or if they give that number of indications of perseveration, automatism, sound associations, repetition of stimulus words, etc.

6. In the performance tests if the age norm for the various tests differs by more than four years, this may be taken as an indication of psychopathy.

7. The orientation test becomes significant if it is unusually poor as compared with the child's mental age or if it is unusually good and shows a verbalistic tendency.

8. If the school work of the child as indicated by actual school tests shows ability which is two grades or more above what would be expected of the child of the given mental level, it may be taken as an indication of psychopathy.

9. Lack of coherence, ambiguity, lack of circumstantiality, etc., in the child's story of his own life may be taken as an indication of psychopathy but this must be evaluated in the light of the child's age and mental age.

10. The child's behavior during the examination is another way of obtaining an indication of psychopathy. He is abnormal in this respect if he shows extreme lack of adaptation to any test, negativism, peculiar emotional reactions, extreme excitability, etc.

The psychological examination finished and a decision reached on basis of these findings, we next consider the history of the case, first personal and second family. These facts may confirm or they may contradict the psychological findings.

The personal history facts that indicate psychopathy are as follows:

Behavior Indications.—This wrong quality of functioning shows in the behavior of the psychopathic child. The major symptoms are similar in most of the cases, some show one phase and

some show another. The children are usually more or less solitary; they do not get along well with other children of the same mental level. If they are feeble-minded psychopaths they are constantly disagreeing with other feeble-minded children who are not psychopathic. This same is true with a psychopath of normal level among other normal children. They are apt to prefer adults to people of their own age. Their games may have a queer monotony which makes them seem peculiar even in their own family. They are especially apt to have strong likes and dislikes as regards food. Those of low grade are unusually destructive of toys, clothing and even of household things which they should not interfere with. They are apt to have violent tempers and have often been recognized as different from the time they were babies. They may be moody. Most of them tend to be rather more easily depressed than to be pleasurably excited. Now and then one gets a case which cannot be depressed but is what we call "exalted" and spends his life at the other end of the emotional plane. Psychopaths are not usually very fond of other children or of pets, although they may have what we call "night terrors," that is, they will wake suddenly crying and have to be soothed before going to sleep and will remember little of the episode the next day. Just what the connection is we do not know, but they are often persistent sufferers from nocturnal enuresis, even to the age of 14, 15 or 16.

School Indications.—They may get along fairly well in school until they reach the fourth or fifth grade, sometimes even later on than this, but they are apt to be poor in spelling and in geography. Sometimes they are poor in all subjects but these are relatively poorer than the others. They are usually difficult to handle in the regular grade work. Every school room has one or more of them. They are the children on whom the teacher can not rely and concerning whose misbehaviors she is always worried, for they are different and the regular punishments do not fit."

The above from an unpublished paper by Dr. Mateer well indicates the symptoms of the condition.

As to the cause of these conditions in children, little is known. Many of them are cases of congenital syphilis and in the absence of any other known cause it is natural to think of this as the causative agent. This is a matter for serious study and really

points to the need of careful physiological investigation of the blood and other body fluids of this type of child.

Anti-syphilitic treatment has been administered in a number of these cases but as yet no marked results are reported. This, however, would of course not invalidate the hypothesis of syphilis as a cause since it may well be that, the damage having been done, nothing can cure it.

As to prognosis and treatment of the general run of psychopathic cases still less is known. Some cases that do not seem to be associated with congenital syphilis seem to get well; the natural growth processes apparently overcoming to a large extent, if not completely, any effect of the disturbing factor. So that while these cases may show the marks of the disease to the expert, nevertheless the condition does not so far interfere with life as to make them distinctly abnormal personalities.

Apparently another group remains unchanged and the victims grow up to be nervous, unstable men and women, easily becoming delinquents and anti-social members of the community.

A third group grows progressively worse and finally distinctly insane and contributes to the adult insane population. In the case of the syphilitic, as already stated, anti-syphilitic treatment seems to be indicated. As for the others, little is known beyond special hygienic measures, regular living and the best possible environment; good food with as much outdoor life as possible; and from the moral standpoint strict and firm but not harsh discipline; and in general, conditions that make for happiness.

The possibility that any considerable proportion of this group of juvenile psychopaths is incurable and must be expected to grow into psychopathic adults, with all the possibilities of criminal activities, is one that calls for serious consideration.

There is no more pressing problem than that of curing or preventing this condition.

DISCUSSION.

DR. MURDOCH.—The juvenile psychopaths are, as a rule, easily differentiated from the feeble-minded. The erratic response to intelligence tests in these cases, as pointed out by Dr. Goddard, is suggestive and adds a valuable aid in the differentiation of psychopathic conditions from simple arrested development.

The most common form of psychosis found in institutions for the feeble-minded is dementia præcox. Cases of juvenile paresis are also frequently found in these institutions. The practical question is whether these psychopathic children should remain in institutions for the feeble-minded, or be transferred to hospitals for the insane. Cases of dementia præcox, as a rule, are prevented from deteriorating and are improved by the school training given in institutions for the feeble-minded, and it would seem that these children receive a more appropriate environment in such institutions, than in hospitals for the insane. The juvenile paretics are appropriately cared for in the custodial department of these institutions. It frequently becomes necessary to transfer cases of manic-depressive insanity, over 16 years of age, to hospitals for the insane on account of their dangerous and destructive propensities.

If institutions for the feeble-minded are to care for these psychopathic cases, they should have proper laboratory equipment for diagnosis and treatment. There is an enormous amount of pathology in our institutions for the feeble-minded. These institutions offer a fertile field for the neuro-pathologist.

INSANITÉ, LEGALITÉ, INSECURITÉ.

By C. B. BURR, M. D., FLINT, MICH.

Some years ago, I was consulted in the case of a young man for whom there had been made application for guardianship. He did not care to appear in court or contest the proceedings: was to outward seeming in sympathy therewith. Letters of guardianship as to person and estate were granted and it seeming desirable that he should have care in a sanitarium remote from home, I accompanied him to one in a distant state. His cooperation was perfect and the trip made without the slightest unpleasant incident—was so care-free in fact, as to constitute an agreeable holiday for myself.

After a number of months, it appearing expedient to change his environment, the plan was broached and measures were instituted to transfer him to another sanitarium. There was at first apparent willingness on the part of the patient, a willingness which in the interim devoted to negotiations, was ditched by collision with the law represented by an attorney who advised that there was no hold upon him and that guardianship in the state of residence was without validity in another. He was soon afterward discharged and the wires conveyed the news to an anxious father that he was wasting the latter's substance in riotous living in an eastern city whence he soon drifted to Chicago for larger opportunities in the same line of activity. The situation was saved by the war. He enlisted and served creditably in France.

On a balmy summer evening an automobile appeared in the offing near the Women's Department of Oak Grove and a patient, resident of another state who had been committed to the care of the hospital by the local probate court, was hustled therein by her daughter (who by the way had theretofore visited her on several occasions and had written divers and sundry letters indicating a sympathetic attitude). In the language of a none too intelligent employee reporting a patient's elopement, the outfit was soon "running rapidly away." To continue the apparent

digression, Dr. Hurd made the distinctly apropos inquiry, "Why aren't you running rapidly after him?" which may with some force be directed to others and myself in the instance under discussion. We didn't and the reason why we didn't is that the Ohio line is distant but a few hours and before we could get fairly started much of the highway thereto would be burned by the fugitive car. A state line in such a case practically offers open door to a harbor of refuge and were the minions of the law therein notified of the incident and the party arrested in its flight, what would happen? Extradition proceedings as in criminal practice, bonds, bailing out and bawling out, injunctions, habeas corpus, appeals, and God knows what. Wherefore "I done sit tight" and let her go, washing my hands, likewise my potentially flying feet, of the whole obnoxious business. What's the use of going out to meet trouble?

It is pertinent to inquire in view of probable disappointment had the law been invoked in either of these cases, what means a clause in the United States Constitution. "Full faith and credit shall be given in each state to the public acts, records, and judicial proceedings of every other state and the Congress may by general laws prescribe the manner in which such acts, records, and proceedings shall be approved and the effect thereof." In the language of the street, this listens and looks good. It would seem possible to liquefy and utilize it, "Thaw" it out as it were, but such proceedings have not been attempted so far as I am aware.

Pardon this time a real digression. I discovered in reviewing our bill of rights in order to find the above article and quote it correctly, another which reads as if written for a libation, "The President shall have power to fill up all vacancies," etc. We have been led to believe that the President had powers approximating the autocratic but this would apparently thwart any disposition he might have to fill a vacancy *down*. In other words, he must appoint as good a Postmaster General as the present in the event of the latter's retirement.

By a modification of human fly acrobatics, a patient once separated himself from an environment which we had certainly attempted to make congenial. He, a non-resident, had been com-

mitted to the care of Oak Grove, after a hearing in probate court which he personally attended accompanied by counsel. This was many years ago and periodically since, all who were in any way connected with this adjudication, the examining physicians, Oak Grove's attorney, the then probate judge, the then head nurse in the men's department, witnesses as to his mental condition, and myself, have been haled into court for some ostensible reason or called upon to do something or other in connection with the case. Bills of various kinds, including those paid by check, have been much in evidence. Twice, a declaration or a writ, or a petition, or some other momentous document has been flashed and we have been required to make answer in the Federal Court. On the first occasion, the petition, or whatever it was, was dismissed. The second was carried on appeal to the United States Supreme Court and a portion of the time of that august and busy body (no reflection intended) was taken up with the formulation of an opinion from which the following extracts are made. Reading between the lines, one may discover in it, a contribution to American humor:

Blank vs. Burr et al. Appeal from the District Court of the United States for the Eastern District of Michigan.

Appellant, having been for a time confined in an asylum as an insane person after due proceedings in a state probate court, took no appeal or other proceedings in the state courts, but long after his escape filed this bill against the owner and officials of the asylum, the present and former judges and registers of the probate court, and others, to regain certain documents and set aside the inquisition. Held, that no construction or application of the Constitution was involved, and hence this court lacked jurisdiction of a direct appeal from the District Court.

Appeal dismissed.

The opinion refers to the bill as "a nebulous recital of grievances against defendants and many others" and states that "all equities of the bill are fully denied in the answer: and the claim that the cause really involves construction or application of the Federal Constitution is without foundation.

"We have no jurisdiction to entertain the appeal and it must be dismissed."

Strictly speaking, is there any such thing as the "right of appeal?" A right would seem to imply universality, but one

surveying the matter from the top of a horse chestnut gains the impression that this particular right is limited to those of adequate financial resources and that with these the sky's the limit.

A firm of attorneys has shown commendable altruism and interest in the so-called "unfortunate," a species of which you have doubtless heard from time to time. One patient who had been twice committed to the care of Oak Grove by the probate court of her county of residence was the object of their especial solicitude and good will. She had the freedom of the grounds and practically of the city and was readily accessible to any perfervid missionary. I quote the patients' own words: "He told me that he would have me out; that he had gotten another woman out from Oak Grove and that my brother would have to come across."

What would you have done? I communicated to her brother, the guardian, that my hat would be shied into the ring if he wished to bother with the matter, but rather than any good eggs should drop into this particular variety of philanthropy's basket, I would recommend that other provision be made for the sister. The advice was promptly followed and neither glory, nor reward, other than that proverbial as to virtue, has "come across."

During the war everybody but Dr. Brush was compelled to accept a lower standard in personnel of employees. Mine dropped so far at one time as to sound the abysmal depths. Except for an incomparable organization built up in the olden times it would have been impossible to carry on.

The picture of one individual employed to stop a crevasse in the levee is clear in my mental vision. He had complete opacity of the right cornea which gave to the otherwise unprepossessing face a sinister appearance. Eventually he resigned or disappeared and the place that once knew him, knew him no more until a few months ago when he was violently projected into the composite consciousness of the medical and nursing force through a note from the firm of attorneys mentioned in connection with the preceding case. This set forth that while employed by Oak Grove he was ordered by the head nurse to receive a shampoo. No doubt he needed it and directing his footsteps to the knight of shears and soap would have been a highly praiseworthy performance. It happens, however, that he ambled thither on his own account, motivated perhaps by a hygienic hunch, possibly

by sheer imitation of what he had seen practiced among those for whom, liberally construing a word, he was "caring."

But to resume relationship with our mutton. The note revealed that the aforesaid barber had introduced shampooing liquid into an eye and that this had caused blindness. "Damages, my Lord, heavy damages" pervaded the lines written by this modern Sarjeant Buzfuz. I am unable to quote exactly, having turned over the claim for compensation to the attorney of Oak Grove. The shampooing liquid by the way was made in the hospital dispensary, and was entirely innocuous. A fact developed on inquiry following the receipt of the letter which is of no little significance, and I trust was unknown to the Sarjeant at the time he wrote. Some time before the shampooing episode, the subject was walking in town with a humane patient; became suddenly blind, was taken by this patient to an oculist, was escorted home by the patient, stumbled into the house and was for several days incapacitated. I do not know what was discovered by the oculist. In view of the demand, I have not been sufficiently interested to inquire.

Probably under the inspiration of, at all events in cooperation with a so-called "nurse" of porcine proportions a firm of attorneys instituted habeas corpus proceedings and dragged a woman paranoiac from Oak Grove to the court.

In naïveté and trustfulness, I laid cards on the table and asked one of the attorneys what was going on in the back of his head. He replied that the woman was not insane and when I asserted that she was very insane, had been continuously so since I knew her and for years before: that she was under guardianship in another state and had been committed to the care of Oak Grove by the probate court of Genesee County, he shrugged his suggestive shoulders and made no effort to absorb the truth, although among other expressions of my own was the following "Do you suppose that were I never so sordid and self-seeking, there is any motive in the world other than that of fairness to friends and consideration for the patient herself, which would lead me to retain in the household of Oak Grove a patient in the advanced stage of tuberculosis, who spits upon the floors and walls and is a menace to the health of the entire establishment?" Notwithstanding the obvious impressiveness of this interrogatory, he was

unmoved and the case proceeded. No testimony was permitted as to the patient's mental condition, all inquiry hinging upon the regularity of proceedings in commitment. In summing up, the judge said that service was in accordance with the statute, that the certificates of the physicians were in order, that the probate record was in proper form, but that the certificate of Dr. Clarke, then acting medical superintendent of Oak Grove, as to the patient's non-attendance at the hearing, was informal because it failed to contain the words, "improper and unsafe." To be sure the certificate, somewhat lengthier than usual, gave cogent and convincing reasons why it was in Dr. Clarke's judgment improper and unsafe, and furthermore the statute does not require the use of the words in the certificate, but it seemed to be an available Morgan for adverse decision purposes and was apparently the only technicality which occurred to the mind of the judge upon which he would be able to invalidate the order. The section of the statute in question reads as follows: "The alleged insane person shall have the right to be present at such hearing unless it *should be made to appear to the court* (italics mine) either by certificate of the medical superintendent of the asylum or the officers in charge of such hospital, home, or retreat to which he may have been temporarily committed, or by the certificates of two reputable physicians that the condition is such as to render his removal for that purpose or his appearing at such hearing, improper and unsafe." Observe the words: "Unless it shall be made to appear to the Court . . . that the condition is such as to render his removal for that purpose or his appearing at such hearing, improper and unsafe." Obviously it did thus appear to the court and the evidence thereof is the order of commitment. The patient was released to the care of the Nurse-Attorney Benevolent Association and died two or three weeks later under conditions which obtain in a cheap hotel across the street from a railroad station.

The judge, immediately after giving the Solomonic decision, said to me, "Now, make application to the Probate Court again for her commitment." I said, conjecturing more than I care to reveal, "No, sir! You have relieved me of a great responsibility which those assuming it may now carry. I have no disposition whatever to follow the advice."

The dramatis personæ of a story by Irvin S. Cobb, entitled "It Could Happen Again To-Morrow" are as follows: A quiet patient with hands confined, a man and woman attendant accompanying her to a private institution, a Miss Smith who took the only seat vacant in the railway carriage, by the side of the patient (Miss Smith is an official of the secret service) one Dr. McGlore, an examining physician, the sanitarium superintendent, the judge of the court of record, the governor of the state, the mother, entertaining persecutory delusions directed against the alleged insane daughter who under interrogatory by the medical examiners had stood entirely mute and permitted them to derive all their information from the plausible mother herself.

Inquiry on the part of Miss Smith revealed the facts of the case: discovered the mother in the psychopathic ward of Bellevue Hospital and effected the release of the patient who accounted for her conduct in not communicating to the physicians her mother's peculiarities by the statement that she had but recently suspected the morbid mental condition and was so shocked that she kept the matter to herself.

I felt that on account of the extreme susceptibility of the dear public to romancing that Mr. Cobb should not get away with the matter without a voice being raised in protest, and accordingly wrote him the following letters:

December 5, 1919.

Mr. Irvin S. Cobb:
c/o Saturday Evening Post,
Philadelphia, Pa.

MY DEAR SIR.—I am a very sincere appreciator of your literary work, but write to take exception on the ground of expediency to your story, "It Could Happen Again To-morrow," in this week's *Saturday Evening Post*.

Everything is being questioned and it is only necessary that a head appear in the curtain to attract the baseball. Many people nowadays are concerned with change,—must have it at whatever cost. What has been and is, is regarded wrong, apparently because in existence, and what is not is apparently deemed desirable because nothing hitherto has been perfect. In what may be termed for lack of a more accurate expression the "mind" of these large numbers, change is regarded the equivalent of reform and procedure in some other direction than that of the (relatively) beaten path is assumed to be progress. Personally, I am convinced that this disposition along with avarice are the principal factors in the existing

world chaos. If so, it seems scarcely prudent to augment the tendency to doubt and misgiving and as a corollary to increase the menace to the unseaworthy craft (the present social status) in tempestuous weather.

Such an instance as that of which you write might happen—obviously—but the fact that it never did happen in my personal experience with upwards of 7000 insane patients is significant. It might happen (I know of no reason on earth why it could not) that the State of Pennsylvania or Michigan should be completely obliterated by a seismic convulsion—but to emphasize the possibility of anything so improbable would be inexpedient. I read yesterday an editorial admission of the withholding of a gloomy prediction by one Professor Porta.

Over a period of more than 40 years I have been moved in but one instance to question the findings of a Court which committed. In that instance an assistant and myself took pains to visit the neighborhood whence the patient came, and investigate personally. The judgment of the court was fully confirmed. There was no doubt whatever in the mind of either that the ends of justice and the public weal had been met.

I have been familiar with two or three cases where habeas corpus was invoked to secure the release from a hospital for mental disease. In no adjudication, when this action held, was due account taken in my opinion of the morbid mental condition and in one shameful instance a mere technicality was employed to invalidate a certificate, although the law, wisely and fairly interpreted, would not justify this petty subterfuge.

In concluding an overlong communication:

First: Do you know of any law adequate, as administered, to invariably insure the ends of justice?

Second: Is it not wiser under the conditions complicating all jurisprudence in this country, to adhere to what has been mainly effective and satisfactory, than to tear to pieces a statute as your (assumed fictitious) Miss Smith contemplates, in order to meet an exigency which has, so far as I am aware, never arisen?

Would not the danger be incurred of other pitfalls? And after a period during which the new statute might be "time tried and fire tested" what would hinder the next reformer from similar acting in exploitation of a pet hobby?

Unfortunately, we are living in an imperfect world and one agency (the law) looking to its protection is too often, as administered, shockingly inadequate to the end in view.

Physicians are taught (even your Dr. McGlore) to admit testimony from every quarter, and to weigh it as fully as possible for the benefit of patients and the public. The lawyer, on the contrary, is educated to exclude testimony in order that his client may exclusively be benefited. I dare maintain that there is no such animal in captivity, as an impartial decision of court, where an emotional coloring has appeared in the testimony. Judges cannot be superior to the motivation of feeling and it is not unlikely that more than one, conscious of this, has stood so erect that he has leaned backward.

Iconoclasm and reform are differentiated by Mr. Taylor in an article on Bolshevism in the same number of the *Post*. I have been afraid that the boat over here was shipping too much water but we are a restless crew and can't sit still.

Very truly yours,

P. S. I have been for years in charge of a private hospital for mental disease, but if you will take the pains to read the enclosures you will discover that no selfish concept influences me in this lamentation.

December 6, 1919.

Mr. Irvin S. Cobb:

MY DEAR SIR.—In my letter of yesterday, I used the expression "my personal experience with upward of 7000 insane patients." With this would perhaps naturally go the implication of more or less close acquaintance with the experience of others in the same line of work, representing a clientele of hundreds of thousands, among which I never heard of a parallel or near-parallel to your case. This should have been but was not stated.

Very truly yours,

C. B. BURR.

Very promptly came a reply from Mr. Cobb as follows:

OSSINING, N. Y., December 9.

MY DEAR DR. BURR.—I thank you for your letter even though we do not agree on some points.

Any law may be administered badly but to my way of thinking it is easier to commit injustice under a very faulty law than under one not so faulty—and I believe the laws of this state touching on the commitment of supposedly insane folk to be very faulty indeed.

Yours sincerely,

IRVIN S. COBB.

I submit, is this not begging the question?

When an entire system of jurisprudence is based upon finical definitions of words and phrases undefinable (as most words and phrases are for that matter) there is something radically at fault. Apparently, there is needed infusion of common sense and elasticity in interpretation of sentences and paragraphs in laws, the intent of which is perfectly obvious. Take for example, the phrase in the Constitution, "Due process of law," without which one may not be deprived of life, liberty, or property. In a Minnesota decision, many years ago, "Due process of law" applied to insanity cases was construed as meaning that before commitment to the care of a hospital, patients should have trial by jury:

that those who had not enjoyed this questionable blessing were illegally under care, and that their constitutional rights had not been respected. This is obviously tantamount to declaring that an invalid is not entitled to medical attention in an organized institution for the insane until convicted of the crime of being ill. To be sure, deprivation of liberty without due or undue process of law occurs daily in general hospitals and in homes the world over when it becomes necessary to restrain or control a delirious patient to prevent his jumping out of a window. You will observe the distinction without difference. One is assumed to be one thing and another, another. They equal the same thing but paradoxically do not equal each other.

In so-called Chancery Courts, reluctant spouses are required to separate themselves from alimony for the benefit of divorcees. This is apparently deprivation of property without due process of law, unless a jury (*rara avis*, in this instance) has passed upon the matter. It is a noteworthy and from the viewpoint of the pettifogger, regrettable fact that much of the success which has attended the administration of juvenile courts in Toledo, Denver, and elsewhere has arisen from the determined opposition by the judicious as well as judicial officer to publicity in matters pertaining to the momentary status of a delinquent or mischief making boy.

Fortunately for the permanency of the throne of good-sense, the Minnesota decision has not been influential in producing the wide-spread scandal of jury investigation in cases of insanity and the protests of legal vultures in justice and police courts against the methods in vogue to provide for juvenile delinquents have not been effective. However, there are compensations.

A great katouse is soon to be made over the definition of "concurrent." As to this, some who have in previous years enjoyed other diversions than those furnished by the scientific program of the Association, will bid the contestants go to it and tangle up matters as much as possible. But this may be construed as personal and therefore incompetent and irrelevant.

The question of the determination of feeble-mindedness need no longer concern psychologists or members of the medical profession of Michigan. It has been assumed by these superfluous

groups of individuals that they knew something of the subject and had duties to perform anent the same but their presumptuousness is adequately rebuked.

Judge Larwill of Adrian in determining the status of a certain inmate of the Industrial Home for Girls, "directed a fire of rapid fire questions by spoken questions at her" * (sic). His interrogatories designedly turned from one topic to another and the girl made prompt, intelligent, and apparently correct answers. She said that she had difficulty in school and expressed a great dislike for arithmetic: that she was twenty years old, had been in the Adrian Home five years, and had had four years in the public schools before her commitment to the Adrian institution.

In his decision, the judge said in part that the question presented to the court by the filing of the petitions (thirty-five in number for the purpose of making transfers to the Michigan Home and Training School) was as to what degree of mental incapacity or defect constitutes feeble-mindedness, as that term is used in the law. So far as he could learn, the question had never been passed upon by the court of last resort. He quoted the dictum of a judge in a neighboring county who had held in construing the statute that "feeble-mindedness in the law" (also sic) must be such a mental defect as would be apparent to the ordinary layman and could not be predicated upon any finely-drawn distinctions of psychologists or alienists, as to the various classes of mentality.

The examining physicians were unable to testify that "the average person would detect a subnormal mental condition from a casual observation of any of the four girls" whose cases were then under consideration. It may be this was for the reason that they wouldn't recognize the average person if they met him. But this is afiel and be it as it may, the ordinary layman is the elect of the decision. While the court conceded that the testimony showed that some of these girls, if not all of them, are of a low type of mentality, that some of them manifest vicious tendencies, that some of them lie, steal, and destroy things without apparent reason: that all of them are of a very backward mental develop-

* Report in a newspaper.

ment, he maintained that if the rule established by the courts is the correct one, etc., the petitions must be dismissed.

Now we have our bearing in Michigan and the Ship of State is without a list. As soon as legal brethren classify its crew into infra-ordinary, ordinary, and extraordinary and so isolate and safeguard the groups that there can be no possibility of intermingling or moving from one to the other, the foghorn of the proletariat and the search light of the philosopher will be alike unnecessary and sailing the simplest sort of endeavor for the "ordinary" seaman.

DISCUSSION.

DR. RICHARD DEWEY.—Dr. Burr has given us in his usual cogent style a very entertaining paper and also presented some points deserving serious consideration. I have listened with great interest to the portrayal of the difficulties resulting from the extreme jealousy of the law in regard to personal liberty. The object of the law is, of course, to obviate and prevent all improper interference with personal liberty. There is often a great reluctance on the part of the insane person or his friends to a judicial inquest and public record of insanity, but a public record is the only thing that will satisfy the law, and so long as human nature remains what it is, these difficulties are sure to occur in so-called "border line" cases. One remedy for them is greater enlightenment, the education of people to an understanding of the purposes that justify interference with liberty; and there is a great mass of ignorance and prejudice in the minds of the people with reference to these matters, grown out of wrongs that existed in former times and it is not understood that at the present day those wrongs have been to a very great extent obviated. These prejudices were created by the stories that have been universally circulated in books, also in columns of the newspapers, giving purposely a sensational turn to all facts and circumstances—(an unfortunate characteristic of the newspaper). These difficulties are being to some extent overcome. Laws permitting voluntary commitment to institutions and treatment in psychopathic hospitals; the operation of laws which allow a court to commit temporarily with a view to ascertaining more fully the mental condition, and laws which allow a person suspected of insanity in connection with crime to be committed to institutions for a period of examination and study, are, to some extent overcoming these difficulties, but they are very slow in yielding, and very unfortunate and even absurd situations have been brought about. A few years ago I knew of a case in which the court released a "habeas corpus" patient, an unusually keen and bright man, himself a lawyer, who was able to bring a large number of friends and acquaintances into court who swore that he was perfectly sound in mind. The judge felt that it was impossible to remand the patient, yet was not satisfied that he was entirely sane. He

therefore sent word to the court in which this man's property was being held in trust that no change should be made in his *status* legally. In the probate court therefore he was still *insane* while in the circuit court he was *perfectly sane*.

THE PRESIDENT.—Dr. Burr, have you anything to say in closing?

DR. BURR.—Nothing, except to thank Dr. Dewey for taking me seriously.

OUT-PATIENT OR DISPENSARY CLINICS FOR MENTAL CASES.

By DR. E. STANLEY ABBOT,

Medical Director, Mental Hygiene Committee, Public Charities Association of Pennsylvania.

It would hardly seem necessary to define what is meant by an out-patient or dispensary clinic. But a word or two about what is included in the term may not be out of place.

An out-patient clinic serves two functions, not wholly separable. One is the continued treatment of persons living in their homes, who come periodically or as needed for guidance and direction. The other is merely diagnostic and advisory, without continued treatment—a consultation clinic. There are usually a fixed place, fixed dates and fixed hours. But in recent years traveling clinics have been inaugurated; and in the list of out-patient clinics for nervous and mental diseases published by the National Committee for Mental Hygiene are included several more loosely organized—if one may even call them organized—opportunities for consultation. Some of these are described as a willingness of the superintendent of a hospital for mental disease “to advise at the hospital discharged soldiers, sailors and marines who are suffering from nervous and mental disease,” without mentioning any day or hour; others, as that members of the staff will see out-patients “daily from 9 a. m. to 4 or 5 p. m.” or, in the case of some hospitals, “by appointment.”

It is questionable whether these latter “clinics” may properly be called such, though it must be recognized in the first place that many of them are the seeds which will undoubtedly grow to be full-fledged clinics, in the commonly accepted meaning of the term, and in the second place that the meanings of words change and grow. Such a change has already happened to this very word “clinic,” which has meant a person sick in bed, a physician, and bedside instruction to students by a physician, before it meant a

dispensary, or place with personnel to which the ambulant patient could come for medical advice and treatment.

Probably from time immemorial physicians in mental hospitals have given advice to the few occasional persons who sought it there. These physicians have apparently been holding out-patient clinics without knowing it, and just discovered it, perhaps like the Frenchman who suddenly discovered that he had been talking prose all his life.

It is, however, not of these, of which 43 are listed, that I shall speak, but rather of the more organized types, to which reference has already been made.

So far as I have been able to learn, the first real out-patient clinic for mental cases in this country was established at the instance of Dr. John B. Chapin, then superintendent of the Pennsylvania Hospital for the Insane ("Kirkbride's" as it has long been familiarly known) in the out-patient department of the Pennsylvania General Hospital. It was opened November 1, 1885 "for advice and treatment of mental diseases in their early or incipient stages occurring among the poor and indigent, when such diseases have not so far progressed as to require restraint within the walls of a hospital."¹

Two assistant physicians from "Kirkbride's," Dr. E. N. Brush, and Dr. H. M. Wetherill, alternated in seeing patients on Mondays and Fridays at 3 p. m. The work seems to have been comparable with that in the other special out-patient clinics. Both neurological and mental cases were treated. During the first six months 40 patients made 87 visits. The clinic has continued with little or no interruption ever since, with an average attendance not varying greatly from those figures. In the last decade there have been as many as 118 new cases in one year (1915) and as few as 54 (1911). From a half to two-thirds have been mental cases, the others neurological. Comparatively few cases of feeble-mindedness were reported.

Until last December, *i. e.*, for 34 years, little effort was made to change the character of the clinic or develop it further. Since

¹ Annual Report, Pennsylvania Hospital, 1886. See also Institutional Care of the Insane in the United States and Canada, Vol. III, p. 415.

then, under the guidance of Dr. Owen Copp and the actual direction of Dr. E. A. Strecker, increased space has been taken, electrical and other equipment for treatment has been added, social service work has been inaugurated, and the medical staff increased. The clinic is held three times a week and already as many new cases attend in a month as formerly came in a year.

The next out-patient clinic was started twelve years later by Dr. Walter Channing, with Dr. Arthur C. Jelly as his assistant, at the Boston Dispensary in December, 1897. His reasons included the desire to give clinical instruction to medical students and to the practicing physicians, and to relieve the other out-patient departments by taking their puzzling cases, as well as the desirability of having skilled advice for the prompt diagnosis of doubtful cases and the commitment of those needing it, and for the care of incipient cases in the community.

Dr. Channing was far-sighted in his day, and foreshadowed some of the recent developments. Writing of his clinic in 1901 (*Dispensary Treatment of Mental Diseases*, AM. JOUR. INSANITY, Vol. LVIII, 1901) he speaks of the clinic as a preventive agency. He was impressed with the number and importance of the feeble-minded. "An increasing number of defective children has been brought to us, and we believe that such a department can do much good in calling attention to these children," whose condition is not likely to be recognized, and who become a menace to society. "It is my desire to make the diagnosis of *defect to an abnormal degree in children* an important branch of work in our department." Like Dr. Chapin, who in his annual report for 1887 wrote that it was not to be assumed that incipient cases should necessarily be put in a hospital, Dr. Channing did not believe in hospitalizing every patient. "It is quite as much the province of the specialist to treat patients out of the hospital as to get them into it. . . . There is a big field for the psychiatrist outside of the hospital."

"A mental clinic should strive to investigate a few cases thoroughly, . . . and a good deal of time should be spent on the consideration of the sociological factors." This, remember, was nearly 20 years ago, before medical social service work was established.

At that time the dispensary was treating upward of 50,000 cases a year, some in their homes, the rest as ambulatory cases coming to the out-patient department. In the first three years Dr. Channing saw 372 mental cases, including 65 feeble-minded, many neurasthenic and psychoneurotic cases, as well as frank psychoses, epileptics, alcohol and drug habitués, etc.

This clinic was active while conducted by Dr. Channing, but for many years it remained about stationary. It is now conducted by Dr. A. W. Stearns.

Probably the first out-patient clinic to be held at a mental hospital was started 29 years ago. For several years Dr. Howe, superintendent of the Massachusetts School for Feeble-Minded, at Waverley, had seen there children who were brought by physicians, parents or others interested, for examination, diagnosis and advice. There were no fixed hours or days. After Dr. Walter E. Fernald took charge of the school, he continued these consultations in the same way, until in 1891 he assigned Wednesdays of each week for this purpose. The day was later changed to Thursday, which has been the clinic day ever since.

About 1913 or 1914 the school began to send some of its staff to different cities in the state, sometimes at regular intervals, sometimes on stated clinic days. This was in conformity with the plan urged by the State Board of Insanity for the state hospitals for mental diseases. It now maintains a well-organized traveling clinic.

In 1906 the State Charities Aid Association of New York established private clinics for the after-care of patients discharged from hospitals for mental diseases.²

Miss Louise L. Schuyler was active in this movement, which doubtless prepared the ground for the idea that the hospitals themselves might reach out into the community and help guide those who had been discharged from them. This, in turn, has made it easier for the hospital to realize that its responsibility for the patient does not end with his discharge. It also helped bring more effectually to the fore the possibility of the hospital's helping prospective patients and even preventing some from becoming patients.

² Amos G. Warner, *American Charities*, 3d Ed., 1919, p. 318.

At all events, it was in New York, at the St. Lawrence State Hospital, so far as I have learned, that the next out-patient clinic was opened, in February, 1909. On Saturdays, from 10 a. m. to 3 p. m. "poor and indigent persons suffering from incipient mental or nervous affections" might there consult the hospital physicians. Treatment was not given, but the family physician was told of the findings and advised as to treatment.

In that same year the Norfolk State Hospital, at Foxboro, Massachusetts, began out-patient work for inebriates only.³

On January 1, 1913, the Boston Psychopathic Hospital opened an out-patient department, followed on May 1 of that same year by the Henry Phipps Psychiatric Clinic in Baltimore. This latter clinic was the first to be opened by a university hospital. Both of these clinics had the facilities of well-equipped laboratories and consulting specialists in other fields.

In that year New York adopted a state-wide plan, followed in the next year by Massachusetts, of having the state hospitals hold clinics, usually monthly, in the larger centres of population in the district tributary to the hospital, as well as at the hospital itself. These were conducted by one or more members of the hospital staff. This plan has developed rapidly in those two states, and has been creeping into other states, so that now Massachusetts has 33, New York 25, Pennsylvania 9, Michigan 7 and 30 other states have from one to four each.⁴

Besides these, there are clinics held by psychiatrists not on the resident staffs of mental hospitals, or established under other auspices than those of the hospitals for mental diseases. Mental hygiene societies—as in Illinois, Connecticut—or local committees—as in Harrisburg, Pa.—maintain some. The Home Service Section of the Red Cross holds a daily clinic for discharged soldiers, sailors and marines in Philadelphia. The Alumnae Association of the Farmington School, an old established school for girls, supports another clinic—The Farmington Clinic—in Philadelphia. Several general hospitals, some connected with state

³ A. W. Stearns, *Out-Patient Work in the Massachusetts State Hospitals for the Insane*, Massachusetts State Board of Insanity, Contribution No. 34 (1914, 14).

⁴ These figures do not include the 43 apparently unorganized clinics referred to earlier in the paper.

university medical schools (as in Denver, Colo., and others), have mental as well as other special out-patient clinics. Co-operative community mental clinics have been organized in which the Red Cross, Associated Charities, anti-tuberculosis societies, school authorities and health officers or boards, and other social welfare agencies have combined and secured the services of a psychiatrist, either resident in the community, as at Harrisburg, or in a comparatively nearby mental hospital, as at York, Pa.

The most recent development, one which so far as I know is unique in this field, is a clinic held only a few days ago, namely, on May 29, 1920. At the request of the local Red Cross Chapter the Harrisburg Mental Clinic went with a staff of ten, including the psychiatrist, psychometric examiners, oculist, dentist, general practitioner and others, to a town several miles north of Harrisburg, to examine patients. This is a mobile group diagnostic clinic. There have been other traveling clinics, but I do not recall any primarily mental with so comprehensive a staff.

Under these various auspices clinics are held in the out-patient department of a general hospital or other dispensary or clinic; in a City Hall; in a Court House; in a school building; in the rooms of an Associated Charities organization; in a public health service building; in a house altered to suit the needs. Any place where two or three rooms, or a room large enough to screen off two or three places for private examination or interviews can be made to serve.

The ideal *personnel* for a clinic consists of the psychiatrist, a psychologist, a social worker familiar with mental cases, a nurse also familiar with mental cases, and a clinic secretary. If no psychologist is available to make and interpret the psychometric tests, the psychiatrist should be able to use some of the simpler tests, or the social worker or a teacher may be instructed in these, so as to get a rough approximation to the developmental stage in the case of children. If a nurse cannot be obtained, the social worker can help out. And the social worker can act as clinic secretary in case of need. The psychiatrist and the social worker are the absolutely indispensable minimum of personnel. And the clinic can be of some help to the community if even the social worker is only an amateur, or a visiting teacher.

The *methods* of conducting the clinics necessarily depend on available facilities. Where these are very limited, not much more than simple advice can be given as to home treatment or mode of living, or help as to admission to an appropriate hospital or school. Much more is done where the cooperation of eye, ear, nose and throat specialists, dentists, roentgenologists, and the various physiological and pathological laboratory specialists can be secured. These help not only in diagnosis, but in treatment.

Many pre-clinical investigations are made by the social service worker, and by some one familiar with some of the mental tests. Various sociological and medical data are gathered beforehand, including in the case of children or those suspected of being feeble-minded, the mental test age, and are presented to the psychiatrist at the time of the patient's visit.

Follow-up work is carried on by the social worker or the visiting teacher, to see that the recommendations of the psychiatrist are carried out.

In at least one clinic, the Henry Phipps, at Baltimore, occupations of various kinds at the clinic itself are used as part of the therapeutic aids. Some clinics, as part of the social worker's task, secure employment for patients.

The types of *persons* who are directly helped by mental clinics include not only the patients themselves, whose forms of illness hardly need to be enumerated before this audience (except to say that a rather large though variable proportion consists of feeble-mindedness in children), but also the distressed or perplexed relatives or friends of the patient, or the teacher in the school. And, of course, those persons in the community who would have suffered some injury or loss if some certain patient who was or might have been dangerous, had not been properly segregated or cared for. Physicians who have had mental patients in their private or general hospital practices, have brought them to the clinic for consultation and advice.

The ways in which they are helped depend on various circumstances. Many children are helped to better environment in home or school, so that they find themselves in such environment as they can adjust themselves to successfully, or they are helped to adopt better tendencies, habits and attitudes. Thus they are prevented from becoming a-social or anti-social in various ways.

They, as well as adults have some of the physical handicaps removed or lessened. Many adults are kept from getting so ill as to require hospital treatment, and some of those who have been in hospitals are helped earlier to get back into the normal life of their community and to keep from becoming mentally ill again.

The *organizations* that are helped by mental clinics are the schools, including truant and attendance officers, teachers, and the normal pupils; child-caring agencies and other social welfare or relief agencies; the courts, especially the juvenile and domestic relations courts; the hospitals for mental patients, by lessening over-crowding through prevention of admissions and earlier discharge of some cases; and large industrial concerns, both business and manufacturing.

The *value* of the clinic to the *patient* has already been indicated very briefly. To the hospital physician conducting the clinic, it broadens his experience, not only by bringing him in contact with the beginnings of mental illness, which he does not often see in the hospital, but he sees types of illness, such as the psychoneuroses and feeble-mindedness of higher grades than idiocy, which rarely enter the mental hospital. It also increases his appreciation of the value of social factors both in the causation of psychoses and the patient's re-adjustment to community life after leaving the hospital. It brings him out of the isolation of the hospital into relation with his fellow practitioners and other elements in the community.

The value to the *community* of mental out-patient clinics has been well described by Dr. John B. MacDonald, superintendent of Danvers, Mass., State Hospital, which maintains eight out-patient clinics. It is an *educator* not only to the physician who conducts the clinic, but to the physicians of the community who send patients for consultation, and to those who attend, and to the lay public with whom the clinic or its agents come in contact. The community learns that here is a new way and a new place to get help in some of its troublesome problems. The clinic gives a better understanding of what the mental hospital is for, what it can do, how it does it. It breaks down the prejudice against the mental hospital, and brings the latter and the community into

* *Mental Hygiene*, Vol. I, April, 1917, p. 266.

closer, more sympathetic and more helpful relations to each other. It gives the community a better understanding of its obligations and responsibilities to its own mentally handicapped members, and improves its attitude toward the delinquent and other dependents. It prevents various kinds of social maladjustments and their sequelæ. It stimulates other social activities which make for better mental health, as special classes in the public schools, etc., and it has the opportunity, which is taken advantage of in some clinics, of spreading mental hygiene propaganda. The clinic also can gather data for purposes of propaganda.

In view of all these possible personal and community benefits that are derived from mental out-patient clinics, especially those conducted from the state hospitals, and in view of the comparatively small cost of establishing and maintaining them, it cannot be long before that mental hospital which does not maintain one or more out-patient clinics in the territory tributary to it will be looked upon as backward and failing in part of its obligation to the community. The mental clinic is becoming more and more a community necessity.

Speed the day when the physicians, the community and their legislators see the light and act accordingly!

AN OUT-PATIENT CLINIC IN CONNECTION WITH A STATE INSTITUTION FOR THE FEEBLE-MINDED.

By WALTER E. FERNALD, M. D., WAVERLEY, MASS.

A modern institution for the feeble-minded, with its trained personnel, its diagnostic facilities, its highly specialized equipment for training and education, with a vast background of experience, covering the completed life histories of many mentally handicapped individuals, constitutes a civic asset, with exclusive opportunities for individual application, which should be freely available, not only for the relatively few persons who are committed to the institution, but to all citizens of the state who need such services.

In practice, in all such institutions, it has been found that problems of juvenile and adolescent mentality and of maladjustment arising in the institution territory are frequently brought to the institution for advice.

Thus, an out-patient clinic naturally develops to a greater or less extent as a part of the work expected of a state institution for the feeble-minded. This is not only greatly to the advantage of the community, but it is a great privilege and opportunity for the institution staff to be brought in contact with many undiagnosed juvenile mental and personality problems.

At a time when mental clinics are rapidly being organized all over the country it may be of interest to describe briefly the practical working-out of the Waverley clinic.

The Massachusetts School for the Feeble-Minded has been established for 72 years and is located within 30 miles of the homes of two million of the three and one-half million inhabitants of a relatively small state with excellent transportation facilities.

In 1891, the number of outside cases applying for advice had so increased that one day each week was designated as out-patient day, and this practice has continued to the present time, although cases are also often seen on other days. This plan is generally understood by neighboring physicians, social workers, etc. It is also generally understood that advice may be sought freely

by letter or telephone at any time. No charge is ever made for advice given at the school. Over 6000 patients have been referred since 1891.

For several years past from five to ten patients are examined on each out-patient day. A larger number could not be handled with present facilities.

The staff of the school also conduct regular mental clinics in connection with the public school organizations in Worcester, Fall River, New Bedford, and often in other cities. Many other cities desire similar school-clinics. An augmented staff recently examined 41 presumably defective children in one day in a rural school in a degenerate community.

For the year 1919 the clinic at Waverley gave advice concerning 377 patients. Of this number 280 were thoroughly examined, and the others were advised by letter or telephone. The number was much smaller than for several years past, as the clinic was suspended for some months on account of influenza and quarantine for influenza.

Social workers referred 89 cases, physicians 75, parents 69, school officials 36, hospitals 24, courts 17, etc.

Cases were sent from 63 different towns and cities, a majority of the cases living within 30 miles of the school. Thirteen states other than Massachusetts sent one or more patients. Four came from Canada, and one each from China and the Canal Zone.

The cases came from various social levels, and on the whole represented a much higher social and economic status than do the average institution inmates. The very fact that advice was sought implies superior average intelligence on the part of the parents.

The chronological ages of the patients were as follows:

Under 1 year	1
1-2 years	14
3-4 years	29
5-9 years	83
10-14 years	105
15-19 years	65
20-24 years	23
25 years and over	19
Not stated (letter or telephone cases)	38

The largest number was at the 10-14 year period.

These cases come to the clinic because they present problems of some sort. The people who bring them not only want a diagnosis but a prognosis and explicit advice as to treatment and management, often for many years in the future. We have found that worth-while advice must be based upon the most complete knowledge and understanding of the patient, his bodily constitution and make up, his heredity, environment, clinical and developmental history, school record, pedagogical measurements, capacity for family and social adaptation, presence or absence of innate or acquired character or personality complexes, and a thorough psychometric examination.

In practice, it has been found that the significant phenomena of juvenile and adolescent problems may be assembled in certain consistent groups. The following ten "Fields and Zones of Inquiry" furnish a working basis for individual case study, viz.:

1. Physical examination
2. Family history
3. Personal and developmental history
4. School record
5. School examination
6. General information
7. Economic history
8. Social history
9. Moral history
10. Psychological examination

A special syllabus for each field of inquiry has been developed, each on a separate sheet.

A satisfactory examination of a given case requires from one to four hours. The examination is a matter of highly specialized team work. The psychiatrist makes the physical examination and measurements and develops and records the clinical and developmental history. A teacher verifies grades reached in school and definitely measures and records present scholastic capacity and general knowledge. A trained social worker investigates the economic history, social history and evidences of character defect, and immoral or criminal record. The psychologist gives a thorough psychological examination. A nurse is always present. The patient is passed from each examiner to the next one in turn. Each examiner fully records the findings on the appropriate single page

record sheets. A secretary condenses the significant facts on a separate "Synopsis of Findings" sheet, classified under the ten separate zones or fields of inquiry; which, with the detailed record sheets, accompanies the patient to the chief of the clinic.

The patient is then independently examined by the chief of the clinic, before he has read the history as gleaned, or the story of the patient's friends has been heard, and the result of his examination compared with the previously recorded findings. In a long day's work, this procedure is much more stimulating and interesting than to examine a patient whose history already has been read or told. It also inhibits the natural tendency to be unduly influenced by the findings and impressions of trusted associates,—a wise precaution for a properly suggestible clinician! Incidentally, it evolves a variation of clinical technique which minimizes the disadvantages of any more or less routine diagnostic syllabus.

The synopsis sheet is then evaluated, field by field, a minus (—) sign put opposite the fields presenting evidences of defect or disease, and a plus (+) sign opposite the fields with no such evidence.

The case is then ready for diagnosis. Each case is afterwards carefully reviewed in detail by the entire staff.

The diagnostic significance of the findings in the ten fields of inquiry have been described in previous papers by the writer. If the case is one of uncomplicated mental defect a majority or all of the fields will have a *minus* sign. A preponderance of fields with *plus* signs usually means something other than straight mental defect.

The findings in the different fields have an enormous significance, not only as to diagnosis, but as to prognosis, treatment, training and future life history. A mere diagnosis of mental defect, or statement of mental age, or intelligence quotient, is not a basis for intelligent prognosis or efficient treatment and education.

The diagnoses in the 377 cases for 1919 were too individual and complex to be satisfactorily shown in a statistical tabulation, but the following primary groupings show the wide range of patients coming to such a clinic, viz.:

Feeble-minded	93
“ “ and delinquent	101
“ “ “ insane	6
“ “ “ beginning psychosis ...	3
“ “ “ epileptic	2
“ “ “ probably epileptic.....	2

Feeble-minded and hysterical episodes.....	4	
" " " syphilis	4	
" " " cretinoid	2	
" " " other dominant endo- crine symptoms.....	4	221
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Inferior normal, maladjusted or with character defect	14	
Normally-minded, maladjusted	19	
" " delinquent	9	
" " dullness, caused by ade- noids	4	
" " spastic	1	
" " deaf mute	1	48
<hr/>		
Superior normal, maladjusted	2	
" " developing psychosis....	1	3
<hr/>		
Psychotic	20	
Developing psychosis	8	
Psychopathic	6	
Developing psychosis and delinquent.....	1	
Epileptic	7	
Probably epileptic	1	
Psycho-neurosis	2	
Neurosis	2	
Constitutionally inferior, maladjusted....	6	
" " with hysterical episodes	1	
Diagnosis deferred, for further study....	19	
" " child too young.....	7	
" " refused to be examined	1	
" " letter or telephone message gave insuffi- cient data.....	24	105
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In many or all of these cases, a merely psychiatric or psychological diagnosis was not sufficient. The individual diagnosis, to be pragmatic, must take into account the bodily condition, heredity, home conditions and the whole environment, learning capacity, mental symptoms, social adaptability, economic status, and earning capacity, character and personality traits, intelligence level, and other psychological ratings. The mere name of a disease does not get us very far. This is as true of the feeble-minded cases as of the

frank psychoses, and of the various other phases of maladjustment.

The advice given is infinitely varied and often of many dimensions, in accordance with the diagnostic findings, viz.: institution care; home care; special class; private school; private teacher; change of school; change of teacher; let up school pressure; take out of school, and go to work; change of work; treat as delinquent; special medical or surgical treatment; country life; travel; vocational training; add new interests and recreation; place in selected family; modify home environment; etc.

In nearly every case it is stressed that the patient is capable of only partial efficiency in any field, perhaps 40 or 60 or 80 per cent of the average, and that more must not be demanded, and that he will often need to be put on his feet, but that he will eventually find a level where he can live comfortably and happily.

The majority of these problems do much better than we expect them to do.

With the feeble-minded cases, if the home is a good one and the patient suitable for home care, the parents are carefully instructed as to training and management, given helpful literature, and are asked to return the child once or twice a year for further advice, if necessary.

Some of the parents make several or many visits to observe training and nursing methods, and obtain further help. Others write many letters for this purpose. The prospects for successful supervised home training of many cases of feeble-mindedness is not generally understood. Many parents will never send such children to an institution. For many years to come, the great majority of such children will receive all their training and care at home. Each patient cared for at home means a saving of \$300 per year for maintenance, and \$1000 or more for institution construction.

One hundred and one feeble-minded cases apparently needed institution treatment for medical and personal care, because of bad habits, or vicious tendencies, or home insufficiency. As many of these as possible were admitted to the institution,—the helpless, those from overburdened homes, those with pronounced character defect, those from highly potential hereditary stock, those with sex promiscuity, and as many as possible of the young morons who would not receive proper training at home. This clearing-house opportunity of the clinic is full of possibilities.

Many of the group apparently needing the institution care were also quite amenable to change of environmental conditions, like letting up of useless school pressure, too exacting home conditions, too little occupation, too little recreation, bad associates, etc. Far too much has been expected and demanded of these inefficient people. A clear demonstration of the patient's limitations and his tendencies often enabled the guardian to manage him well at home.

We have been advising the friends of some of these cases for many years. Some return annually for advice and some only when the patient again gets into trouble.

It is a striking fact that of the thousands of cases diagnosed as feeble-minded at this clinic since 1891, the majority have not subsequently applied for admission and are not known to have seriously misbehaved.

A well marked-out plan of after-care, with regular visitations, would be very welcome to the parents, and would be of great value. As it is now, we are advising more patients under home care than are now being cared for in the institution itself.

Advice was sought in seven cases as to the advisability of adoption; in four cases it was advised, and in three disapproved.

In two cases the advisability of marriage was in question; one was approved and one advised against.

As to the inferior normals, almost without exception we were able to make them happier and better off by easing up the standards of achievement in school, in social life, or in work, which ambitious guardians had expected them to live up to. Too much had been expected of them also. One boy of nine, with an eight-year mind, was most incorrigible in the fourth grade in school, but when dropped back to the third grade, his badness disappeared and he became happy and contented.

The maladjusted normals were often found to be bored with their studies in school, or were nagged by neurotic parents, or were otherwise misunderstood at home, or were at work at uncongenial tasks, or did not have a needed variety of interests and recreation.

Several children, most incorrigible under home conditions, created by parents with no understanding of the primary needs of childhood, promptly began to behave properly and normally when taken from home and placed in a selected family with wise management.

In a surprising number of instances the real difficulty was not with the child, but with the parent or parents.

Two "superior normal" boys in court for repeated truancy and theft, became at once obedient and "biddable" when they were given interesting school work appealing to their superior intelligence, and given an outlet for their craving for adventure by a summer in a boys' camp, and free access to properly exciting boys' story-books.

Many of the juvenile delinquents seemed to be merely expressing their dissatisfaction with the limited opportunities afforded by city life for normal self-expression of boy and girl interests. Here we tried to replace the previous plan of taboo and repression by constructive substitution of attractive and interesting play and occupation, often with prompt happy results.

One girl of 14, fully matured physically, with a normal mind, and with an over-Puritanical mother, was not allowed to play with other girls of her age, or to read any books or to have any recreation whatever. She became truant and sought sex expression as the only possible adventure within her reach. A prescription of pretty dresses, girl friends, daily browsing in the public library under wise guidance, books and papers at home, etc., afforded normal expression for the intellectual and emotional interests of this "little woman who had been treated like a child," and her misconduct at once disappeared.

Very rarely is the reformatory recommended for a juvenile delinquent with a good home.

Dementia præcox is the form of psychosis usually found in these adolescents. Usually the nature of the disease had not even been suspected and the patient had been treated with severity and harmful discipline. A change of environment, a variety of new and simple interests, and a sympathetic understanding of the patient sometimes brought about a temporary comfortable adjustment. Several of the dementia præcox cases voluntarily returned several times, saying they "felt better after talking things over." Of course, the majority of the psychotic cases were referred to the state hospitals for proper treatment.

The pre-psychotic and probably pre-psychotic cases are of great interest. They are seldom seriously regarded by the family physician. They are not usually seen by the psychiatrist at this stage.

They have usually shown suggestive changes in their ways of thinking and feeling and behaving. We do not yet know the danger signals of the school period as portents of future mental disease. All of our youthful pre-psychotic cases were culled out of school by some discerning teacher or parent for some failure of adaptation and not as mental cases. None of them were referred by physicians.

A majority of the cases seen here were of public school age. A study of the mental and personality problems appearing in any high school or college for a decade would yield rich material in this field of preventive medicine. This could only be done by a special public school clinic, so informal and sympathetic and helpful and human as to invite and encourage boys and girls to talk over frankly their problems of adjustment and adaptation,—problems really as old as the human race, but to the boy or girl terrifically new and appalling.

This school clinic should make available for our children in the public schools at the time they need it most the knowledge and experience of skilled and seasoned psychiatrists, neurologists and psychologists. The clinic should have no connotation of the diagnosis of actual mental disease or defect. Cases of developed mental defect or insanity should be diagnosed and handled under different conditions.

DISCUSSION OF PAPERS BY DRS. ABBOT AND FERNALD.

DR. E. M. GREEN.—I feel hardly qualified to discuss in detail the two very comprehensive papers to which we have just listened, for the reason that the only clinic with which I have had any experience is one of the group described by Dr. Abbot as "community organization clinics" and in which the work may appear somewhat superficial if judged by the standard set by Dr. Fernald. I believe, however, that this group has some advantages not possessed by the others mentioned, in that it coordinates the activities of all charitable organizations in a community, assigning to each a share in the service to be rendered, and thereby leads to the discovery of many cases which might otherwise not have come under observation. They may be so operated as to combine the desirable features of out-patient and consultation clinics and in addition to care for a certain part of the social service work of the state hospitals which draw from the districts in which they are located.

The most desirable form of clinic will follow in a measure the plan adopted by associated groups of physicians, the patient being examined first by an internist, then by a specialist in diseases of the eye, ear, nose, and throat; the blood, spinal fluid, secretions and excretions being inves-

tigated by a clinical pathologist, while surgical conditions are referred to a surgeon, and intelligence tests made by experienced examiners. With reports from these sources in hand, and accompanied by full family, personal, and social histories the patient is finally presented to the psychiatrist for special examination, treatment or advice.

The personnel of the clinic with which I am connected includes a psychiatrist who serves also as director, an internist, a specialist, a pathologist, a surgeon, two women experienced in making intelligence tests, two social workers, a stenographer and secretary, all of whom are brought together under the auspices of the Home Service Section of the American Red Cross. I might say incidentally that every item of expense incurred by the clinic is paid by this Home Service Section.

A mental clinic will not attain its greatest possibilities for community service if its activities are confined to the giving of advice and the offering of suggestions as to the disposition of patients, but it must in addition be a place where treatment of both mental and physical disorders can be had, where inquiries as to relatives and friends can be made, where after-care and follow-up work can be carried out. All this we attempt to do in the clinic at York.

A striking feature of most mental clinics is the large proportion of children in attendance, between 60% and 70% of all cases being under 15 years of age. A second interesting feature is the rarity with which true psychoses are encountered among the conditions presented, while a third point of interest is the frequency with which abnormal fears are exhibited in the case of children.

Even in a small clinic the reasons which lead to the appearance of patients are quite diverse. By far the greater number of children are presented because of inability to make satisfactory progress in school, with or without the presence of other symptoms such as extreme shyness, so-called nervousness, motor disturbances, or emotional instability. Difficulties in articulation, accompanied usually by other symptoms, occur in a surprisingly large number of cases. Truancy, wandering from home, destructive tendencies, and delinquencies are responsible for a few cases, while epilepsy and psychotic manifestations each contributes its quota.

The interest of all charitable organizations, heads of schools, courts, physicians, and those concerned in welfare movements of every character can be enlisted without difficulty when the scope of a mental clinic is understood and the cooperation of each group becomes a valuable asset to its successful operation.

I am in accord with Dr. Abbot in believing that if the public is to become informed in regard to mental disorders and mental deficiencies, their causation and prevention, and is to adopt a more reasonable attitude toward such disorders and toward institutions established for their care, mental clinics located in the larger centers of population will prove to be the most efficient agencies through which this educational work can be carried out.

DR. MURDOCH.—Out-patient clinics in connection with institutions for the feeble-minded are an interesting development. Owing to the vast numbers of the feeble-minded being brought to light by various social agencies, and the fact that large numbers of the feeble-minded are getting on satisfactorily in their homes and in the community and do not require institutional care, these out-patient clinics are destined to play a most important part in diagnosing and suggesting proper lines of care and treatment of cases of the feeble-minded not requiring institutional care, as well as those which require special training and supervision within the institution. Mental tests of men drafted for the army revealed the fact that large numbers of men, who were doing useful work in the community, were mentally defective. They did not make good soldiers, but may be usefully employed in the present shortage of labor. The clinic being conducted at Waverley is performing a most useful function. Clinics should be established in connection with all institutions for the feeble-minded near large centers of population.

DR. COPP.—Much as the institutions are accomplishing through these clinics, there is another aspect. The clinics are doing a great deal for the institutions; they are bringing them into their right relationship to the public; they are becoming the source of information—what they ought to be, the natural source of advice to the public along these lines. If we have problems arising on the wards in the treatment of our patients, or other problems for investigation, we send to the laboratory for examination and solution of them. I like to think of the hospital as a laboratory to the community in solving its mental problems. The public ought to look to it for help.

DR. C. B. BURR.—May I ask Dr. Fernald to tell us what he means by a normal individual? Is it a person well set up and physically in good condition, who responds to certain intelligence tests according to his age; and where do the emotional reactions come in?

DR. FERNALD.—I should have said those not feeble-minded.

I just want to amplify one thing I said about the special clinic for the school; that clinic, I believe, should be absolutely dissociated from any suggestion of mental defect. I had special reference to the upper grades in the grammar school and the high school.

THE FIELD OF A STATE SOCIETY FOR MENTAL HYGIENE.

By DR. E. STANLEY ABBOT,
*Medical Director, Mental Hygiene Committee, Public Charities
Association of Pennsylvania.*

The field of a state society for mental hygiene must depend on the field of mental hygiene itself. This has been expanding.

Owing to the causes and method of origin of the mental hygiene movement, and the fact that those especially active in it were psychiatrists, neurologists and other physicians, the tendency has been to think especially of morbid mental conditions, and the methods and facilities for treating them, and for the care and relief of those suffering from them.

But there is a *normal* mental hygiene, which has to do with the factors which affect *mental* development and activity, just as general hygiene—of which mental hygiene is, and some day will be recognized to be, a part—has now to do with *bodily* development and activity.

This normal mental hygiene is positive, constructive, not merely preventive, though it is that, too. It seeks to make the conditions such that good minds shall have opportunity to be better.

Many children in the slums grow up with fairly good bodies in spite of bad ventilation, filth, and unsuitable food, and exposure to contagions. They might have had better bodies had they had a better sanitary environment.

Similarly, many children grow up with normal minds, normal adjustment-habits, in spite of insanitary mental environment.

Hence, there is a field of activity in the study of what constitutes a healthy mental environment, and in applying this knowledge to the whole population.

We may say that hygiene in general is concerned, through *sanitation*, with *environments* that make for health, and, through *personal* hygiene, with the *body*, that it may have healthy growth and development.

Similarly, *mental* hygiene must be concerned with what we may call *mental* sanitation, both of the environment and of the person. It embraces, therefore, the mental *atmosphere* into which the young are born, in which they grow up, and in which the adult has to live, and it seeks to keep this atmosphere clean and wholesome. As a matter of *personal* mental hygiene it seeks the development of wholesome mental states, reaction-types and adjustment-habits of the human being, whether infant, child or grown-up.

Hence, even before the birth of the child, mental hygiene has its place in the pre-natal clinic, to insure that the expectant mother, and the father, too, knows how to create and preserve the best atmosphere for the baby to be born into. This is especially important in the case of the unwilling or the unmarried mother and the unwelcome child.

Health centers and health councils need to be able to teach those—whether parents, other relatives, foster parents, nurse-maids, nurses, governesses, or the officials and employees of child-caring agencies—who care for infants, toddlers and those of pre-school age, how to keep this atmosphere clean and wholesome, free from harmful mental contagions, such as the example of the precocious sex delinquent, etc., in order that the right attitudes and habits may be developed during these most formative and impressionable years.

It need hardly be mentioned, of course, that the public schools, with their opportunities, not only in the school itself, but often in the home, for applying the principles of mental health to all the childhood and adolescence of the land, constitute a wonderfully rich field for mental hygiene effort. For there lies the opportunity, not only for fostering normal psychic health—what we may term orthopsychics—but for the discovery, prevention and correction of much undesirable mental development.

In order that the teachers in public schools may have the requisite knowledge to create the right atmosphere and to teach and train the pupils in wholesome mental habits and reactions, it is necessary that mental hygiene should be taught in the schools for prospective teachers, *i. e.*, in normal schools and colleges. Hence the mental hygiene movement is concerned to that extent with the curriculum of these institutions.

In order that the children in the schools may be carefully examined, to have their education fitted to their individual capacities and needs, *psychologists* are needed to make and interpret the necessary tests or examinations. They are needed to make researches into the mental health needs of children at different age levels, from infancy onward. In the late school years and in industrial life, vocational guidance and occupational placement and adjustment call for the psychologist's help. Hence a mental hygiene program may well include an interest in the adequate training and supply of psychologists and the application of their services in these fields of applied psychology.

All the child-caring agencies have their mental health problems, based on their obligation to secure for their charges such *mental* as well as physical surroundings as will best promote a normal healthy development. Thus mental hygiene interest invades this field of work.

Neither the external conditions which foster mental health nor the individual's habits of reacting can be so completely guided and controlled *after* school years as they can be *before* and *during* them. Nevertheless, mental hygiene is finding a field in industry, where not only can it help in vocational guidance and occupational placement, in detecting the trouble-maker before he makes trouble (perhaps so guiding him that he ceases to be even a potential trouble-maker), and in research as to conditions which may prevent or cause *fatigue* and other states which affect the psychic factors of the worker, but it may also deal with the relations between the foreman or boss on the one hand and the workman under him on the other, between employer and employed, and with other industrial relations. It may thus become one of the agencies which help remove causes of ill-feeling, resentment and discontent, and hence of industrial unrest.

As above stated, normal mental hygiene has its preventive or negative aspect, as well as its positive one. But there are other definite preventive measures which fall within the scope of mental hygiene.

In this field of *prevention of morbid or ineffective mental reactions*, the public schools again offer a most far-reaching and important opportunity, through the introduction of special classes—the adjustment or fitting or opportunity classes as they are some-

times called. In these some of the backward can be brought up to normal level, the dullards kept from discouragement by being set tasks within their capacities, the precocious advanced as fast as is compatible with their abilities and strength, and the nervous, peculiar or difficult child receive special attention, guidance and direction.

The *discovery* and *recognition* of *morbid* mental tendencies, reactions and conditions of persons in home, school, shop or factory, penal, correctional, and charitable institutions and other places of relief or detention, and in the community at large, are problems of mental medicine, solvable largely by means of *mental* clinics, and by *surveys* of institutions and communities. Hence the establishment of such clinics in sufficient numbers and accessibility, the conducting of surveys, and the finding of physicians and others capable of conducting them become mental hygiene interests.

The number of *physicians* with the requisite knowledge of the mental factors in disease and social maladjustments, who can conduct such clinics, make such surveys, give sound advice, and conduct or guide the various types of institutions is very limited. To increase their number, to stimulate the study of mental hygiene and mental diseases, and to increase the facilities in the medical schools and hospitals for research and teaching in these fields, become important interests of mental hygiene.

The *care* accorded to the persons found by these investigations to have mental disease or defect or other mental handicap has been from the beginning of the movement a chief concern of mental hygiene. In this connection one thinks at first of the hospitals for the insane and the feeble-minded, for the epileptic, inebriate and drug addict. But all types of penal and reformatory institutions, almshouses and other places of detention should be equally thought of.

One should also think of the group of persons, many of whom are not in hospitals, namely, the discharged soldiers, sailors and marines who have nervous or mental disease or defect, for whom the government holds itself responsible.

This *care* involves (1) the mental atmosphere (*i. e.*, the external conditions as they affect the patient mentally) in which the patient is to be, and (2) the medical treatment and guidance of the patient.

1. The *mental atmosphere* is affected by (a) the *laws* concerning general organization of care; concerning supervision, control and care of dependents; concerning commitment and admission to, detention in, and release from institutions; concerning the length and character of sentences and commitments; concerning conditions of confinement and opportunity for instruction, labor, and other occupations in prisons and other institutions; concerning appropriations for maintenance, and for increased accommodations in all types of institutions.

(b) The structure of the institution, its location and general adaptability to the purposes it is called upon to serve—especially in relation to proper classification of inmates, that their associates may not be harmful to them—affect the atmosphere in which the inmates live.

(c) The spirit and attitude of the individuals in charge of the prisoners or patients, from the Board of Managers, Superintendent or Warden down to the Ward attendant, or “keeper” are of grave importance. These may be such as to elicit in the inmate reactions which are socially or medically harmful, or they may elicit the best. They may counteract to some extent the influence of structure, location and adaptability of buildings.

(d) The whole atmosphere of the institution will be better if it is a place for research and teaching in the field of the disabilities for care of which the institution was established. For this reason, as well as for the advancement of knowledge of the mental factors in all forms of social maladjustments and of the conditions and causes that determine them, mental hygiene is interested in this *educational* function of institutions.

2. With regard to *medical treatment* and *guidance*, good care requires (a) that there should be a sufficient number of physicians, nurses and attendants, and that they should have the requisite degree of knowledge to take proper care of the patients; and that the institution should have adequate equipment for administering whatever kinds of treatment, including occupations, are best suited to the needs of the patient; these are naturally items with which mental hygiene is concerned.

(b) *Enough* hospitals and institutions of all types to meet the mental hygiene needs of the community are a great desideratum. Psychopathic hospitals, psychopathic wards in general hospitals,

out-patient mental clinics in general hospitals, special hospitals, schools, and other places, and travelling mental clinics are some of the agencies which it is part of the effort of the mental hygiene movement to advocate.

(c) The establishment of facilities for *after-care*, help in resumption of normal life in the community, and guidance in prevention of recurrences of disability fall within the scope of mental hygiene. Social service workers having experience with mental cases and mental out-patient clinics, whether organized by the institutions or by community effort quite independently of any special institution for the care of mental cases, are agents to accomplish these ends. The urging of their employment by institutions may well become a mental hygiene activity.

Since social service workers in general, and especially those who assist in school, hospital or community mental clinics, are constantly faced with problems into which mental factors enter largely, it is one of the interests of mental hygiene to see that they receive instruction in the nature of these factors, their influence and bearing on their problems, and the best ways of applying this knowledge in the care of the patient or case.

The stimulation of public-spirited individuals and various social welfare and other organizations to take active interest in these fields, by informing them of the facts and needs through all kinds of publicity and propaganda, offers a large field for mental hygiene activity.

Thus, to sum up, mental hygiene touches or includes within its field of interest the fostering of normal mental developments and activities, the prevention of abnormal developments and reaction-types, the care of those who are mentally handicapped, and the supply of personnel and facilities to put these into effect. It is interested in *environments*, that they may be wholesome and exert a good influence upon the development of right mental attitudes and habits and upon the correction of wrong ones; in *persons*, that they may have the best surroundings and develop and preserve or regain the most healthful types and habits of mental reaction; and in *institutions* and *agencies* that they may carry on investigations and researches, provide the best guidance and aid in improving environment, and teach, train and help individuals.

What, then, can a state society do?

No one society can cover all this ground at one time. It needs to make selection among all these possibilities. It may take one, or two, or three objects as its major activities, and as many minor ones as it has the opportunity or the money or the personnel to pursue.

The special conditions, needs, or opportunities within the state will largely determine what the activities of a society shall be. When the Massachusetts Society was formed, there was already a good system of care of the mentally handicapped and of laws relating to them, but great lack of general information in the public at large on mental hygiene topics. So that society devoted its energies to propaganda, especially as to preventive possibilities. Other state societies have established and maintained mental clinics, as in Illinois and Connecticut, to mention only one or two. Some states have conducted surveys, as Pennsylvania a few years ago, and Mississippi and Louisiana now.

To illustrate how special conditions or opportunities may determine activities, I will tell of some of those in Pennsylvania.

There was great need of the segregation of feeble-minded women of child-bearing age, but no facilities. A survey was made in one district and an exhibit was made and taken all over the state; after some few years a village has now been opened for the care of that class.

We have county-care of insane as well as state-owned hospitals. To lessen the evils of this system, or rather custom, a survey was made of all county institutions caring for the insane. It has not yet succeeded in establishing state care, but will help, and it has undoubtedly helped to increase the number of state hospitals and the size of appropriations.

The exhibit on feeble-mindedness aroused enough interest in that class to enable the Association to get a bill through the legislature enlarging the scope of special classes in the public schools so as to include the exceptionally able children, and those so handicapped in any way as not to be properly educated in the public schools, and providing for state aid in the support of those classes. The hearty cooperation of the state departments of education and of health has made it possible for us to carry on an active and effective propaganda throughout the state to demonstrate the value

of such classes, and to help in making the law effective, and not a mere paper law. That is one of our present major activities.

At its last session that legislature authorized a constitutional revision commission and a commission to revise and codify the laws relating to the insane and feeble-minded. These opportunities, especially the latter, determine another of our major activities, first, in helping to make good provisions and laws, and, later, to get them through the legislature.

The cooperation with the health department makes possible the introduction of mental health work into the health councils and health centers which are being established. We have done a little propagandizing in this field, but have not yet accomplished much, as the opportunity is a very recent one, and the other activities have monopolized our time.

I might speak of other activities, but those will illustrate my point. New needs or opportunities are frequently arising, or old ones becoming urgent, and there is always the temptation to work at them. For example, we have often been urged to hold mental clinics, which are greatly needed, and the temptation has been hard to resist. But by trying to get cooperation of social welfare organizations and psychiatrists and psychologists to form their own clinics, we think we are doing a better service. Not all states are so rich in opportunities at any one time, but every state has enough to keep a state society fully occupied.

When one object has been accomplished, as when a survey has been made, or an exhibit held, then comes the work of making its application felt, as when the village for feeble-minded women was finally opened. But then comes the work of informing the public of its existence, of how to use it; and soon will come the necessary propaganda for its enlargement. One object accomplished, others follow as necessary consequences. There is always a field of work for a mental hygiene society, and there will always be need of continued and growing activity.

TEN YEARS' WORK OF THE ILLINOIS SOCIETY FOR MENTAL HYGIENE.

By RALPH P. TRUITT, M. D.,

Medical Director, Illinois Society for Mental Hygiene; Assistant Professor of Neurology and Psychiatry, University of Illinois, College of Medicine, Chicago.

The Illinois Society for Mental Hygiene was founded in 1909, incorporated in 1910, and is one of twenty or more organizations in different states, all having in common much the same objects. These objects briefly stated are: To work for the conservation of mental health; to help prevent nervous and mental disorders and mental defects; to help raise the standards of care and treatment for those suffering from any of these disorders and defects; to secure and disseminate reliable information on these subjects and also on mental factors involved in other related problems; to further psychiatric social service and occupational therapy; to aid in the solution of problems resulting from the war; to co-operate with federal, state and local agencies or officials and with public and private agencies whose work is in any way related to that of a society for mental hygiene.

In view of this extra-institutional organization's existence for the past decade, a review of its activities should be of interest to this Association because of its direct bearing on and relation to your work. It should also be of interest to the people of every state in this country so that they might judge the value of its usefulness in the community as a social agency worthy of their support.

The society began its activities in a small way with one nurse who was furnished desk room by one of the women's clubs of Chicago. With added interest, increase in number of cases referred for help and special activities engaged in, it had developed at the close of the recent war and of its ten years existence into an institution of importance occupying a large building, employ-

ing sixteen people in different capacities and a medical director, reminding one in this special field of some rapidly growing business concern without, however, the usual dividends, which social agencies never pay, at least, financial dividends.

I wish to speak of the Society's past work under the headings of its activities : namely, social service, occupational therapy, public service otherwise and a word as to future work.

PSYCHIATRIC SOCIAL SERVICE.

The first work of the society was directed towards social service. It was among the first in this country to recognize the necessity for this most important phase of work in preventive mental medicine. During these ten years personal service has been given to the people of Chicago who have come to the society themselves or who have been referred to it by various agencies. There has been no other organization in Illinois doing similar work during this period.

Starting in this special field with one course, a well-qualified general hospital graduate and formerly Superintendent of Nurses at one of the Illinois state hospitals, it was early recognized that social service had a place of usefulness in the community so that at the end of the period covered by this report there were three salaried social workers, two volunteer social workers and an office secretary completing the complement of the official staff of this department.

We learn from the first year's report that the work was directed towards investigating home conditions of patients prior to parole from the state hospitals and giving after-care to those patients paroled and discharged. There were 647 special instances relative to this early function of investigating paroles during the first five years and more than 1000 cases of this nature were referred altogether while this service was given to the State of Illinois. In this connection a clinic under the direction of a staff physician from one of the state hospitals was held bi-monthly in the office of the society. This very necessary work with both types of cases was continued until a late date when the parole case work was taken over by the state after the society had demonstrated the value of this service to the individual. There is no reason why I should, before this body, comment on the nature

and need for after-care work among the paroled and discharged patients from our state hospitals for the insane. Its need and value you undoubtedly appreciate.

In 1911, after the interest of the county judge was aroused, the society was requested to direct investigations of mental cases in Chicago and Cook County after admission to the Detention Hospital and prior to commitment to the state hospitals. Two social workers were employed from funds of the court set aside for the employment of extra judges. This work was directed by the society for four years (1911-1915) during which time records were made in 8663 cases. When this work was taken over by the county in 1915, there was a director of this department and three assistants retained who continued to function as the social service bureau of the psychopathic wards in the Cook County Hospital. Here the society again performed its function as a private organization, having done the pioneer work and demonstrated its value. Social service is now a most important and indispensable adjunct to the county court.

This department of the society has also functioned for some years as a source for the practical work of many public health nurses and social workers in training in Chicago who elect this branch as a part of their special training for future work. This experience has been not only of value to those people, but society in general and the organization has benefited as well by their services. During the years 1914-1915, clinical material and social service work was furnished by the society to the University of Chicago for use in its classes of abnormal psychology. At the end of this period a full-time nurse was employed by the University.

More recently a majority of the cases referred to the society are examined and treated at one of the out-patient departments in connection with one of the medical schools of Chicago. Here they have the added advantage of the usual dispensary facilities which were not available at the society's headquarters. In this connection a mental clinic has been opened with a psychiatric social service worker in attendance, the first of its kind in Chicago. While this is still in its infancy, it is believed that it will serve as a starting point towards this service being extended to other out-patient clinics of the city.

By far the most important and continuously sustained phase of the social service work has been the interesting of other public service agencies in referring their recognized mental problems to the society for social service treatment. During the past year, patients came to the organization from practically every conceivable source representative among which were: The united Charities, Visiting Nurses Association, Juvenile Protective Association, Jewish Aid Society, American Red Cross, Legal Aid Society, Immigrants' Protective League, Board of Health, children's societies, employment agencies, physicians, hospitals, dispensaries, patients themselves and their relatives, newspapers, industrial concerns, courts, settlements, and so on. In all, more than seventy distinct sources were represented demonstrating the far-reaching effect of mental problems.

During the past ten years, 8934 people with nervous-mental disorders came to the society for help for the most part from these agencies.

Of those patients committed to hospitals, practically all arrangements for commitment were made by the worker in obtaining the necessary papers and co-operating with the hospital by giving a statement or copy of the record of contact with the patient. Frequently the worker accompanies the patient to the hospital. In many instances since the voluntary commitment law became effective in the state, the patient has been induced to take advantage of that measure. So far as possible when any patient was committed, a relationship was established between the family and the hospital and not infrequently the family comes to the society for advice on different questions pertaining to their relative and the hospital.

There are now more than 100 records of ex-service men, with nervous-mental disorder on file in the social service department, referred by the American Red Cross. Two-thirds of these were overseas, most of them are receiving compensation or will receive it, while the social records indicate in many of the cases the existence of the nervous-mental trouble prior to service. One dementia præcox case escaped from a state hospital and enlisted for a few months is now receiving \$80.00 a month compensation. The psychoneuroses lead in this group comprising 33 per cent (chiefly neurasthenia and hysteria) dementia præcox 31.8 per

cent mental deficiency 17.5 per cent, psychopathic and other individual constitutional types 15.7 per cent and less than 5 per cent make up a miscellaneous group including paresis and cerebro-spinal syphilis, the manic-depressive, traumatics and so on.

A brief survey of 500 general cases (not including the ex-service men) referred to the society since the beginning of its fiscal year, October 1, 1919, brings out some rather interesting facts. Regarding the classification of these cases, 37.9 per cent belong to the dementia præcox and allied group, 24 per cent mentally defective, 13.8 per cent psychopathic and other individual constitutional types, 9.2 per cent manic-depressive (mainly the depressed phase) 7.4 per cent psychoneuroses (neurasthenia, psychasthenia and hysteria in the order named), 3 per cent each of paresis and epilepsy and less than 1 per cent of senile dementia, cerebro-spinal syphilis, infective-exhaustive psychoses and so on. There has been a very noticeable lack of alcoholic mental states. Thirty-six per cent of the total group of these cases were recognized as certifiable types, a majority of whom were in need of hospital treatment, yet only 8.3 per cent were actually committed to hospitals, one-half of which were voluntary commitments. Twenty-five per cent of the group had had former commitments to state institutions. So few commitments of recognized certifiable types were partly due to the supervision extended by social service, the lack of institutional facilities for the mentally deficient and in no small degree the lack of commitments in certain urgent cases was due to the ignorance and prejudice of relatives as a result of the old stigma attached to our existing hospitals. Female patients were referred in the proportion of two to one as compared to the males. This is believed to be due to the fact that social workers of these agencies being women more readily form contacts in their work with the female patients. Less than 50 per cent of the cases studied had been registered with one agency or registered with no agency at all, 25 per cent had been registered with either two or three different agencies, 19 per cent were registered with between four and six agencies and 6 per cent were registered with seven agencies and over before coming to the society. A case of long-standing dementia præcox had been registered with nine agencies before being recognized as "mental" and a case of neurasthenia had had eight registrations, both of these had been financially supported from time to time.

As one would expect most of the cases referred are well advanced in their disease, they might have been much earlier recognized by a psychiatrically trained social worker. It was impossible to determine the length of time many of these patients had been under the supervision of other agencies and often wholly or in part supported by them. This special field of social service will undoubtedly always be a part of the work of this organization; it has never been in a position to adequately deal with these problems because of the lack of funds for the necessary increase of workers nor does it expect to develop financially to that point of efficiency. It is anxious to arouse sufficiently the interest of different organizations dealing with social inefficiencies in general so that they might appreciate the large per cent of mental problems with which they are constantly forming contacts and in turn add to their staff the psychiatric social worker. The time is not far distant when this knowledge will be a part of the training of all social workers. Surveys and other information coming from the field of charity work establishes beyond a doubt the need for recognizing the mental factors involved with these agencies. When these mental factors so frequently found involved in social problems are taken into consideration in a more serious manner, better justice will be done to the client, the philanthropist and more often the tax-payer of the state.

One of our leading mental health authorities some years ago in writing of social service stressed the truth that one of the most striking facts to the conscious life of any human being is that it is interwoven with the lives of others. It is in each man's social reactions that his mental history is mostly written and it is in his social relations, likewise, that the causes of the disorders that threaten his happiness and effectiveness are sought. This includes a study of the conditions under which he has lived, his habitual methods of adjustment, his heredity and therefore the social account which has caused his personality to be so colored. The treatment of a patient often means his re-education, his revaluation of the various factors in life, his progress from an immature attitude to one more mature and honest. Difficulties in the life situation of the patient which are open to modification must not be neglected, at the same time more hygienic adaptation to the complex demands of life, the formation of better social

habits, are complex tasks where supervision by an intelligent social worker is invaluable. This truth still holds good and we are apparently in the beginning of its re-constructive usefulness.

OCCUPATIONAL THERAPY.

For some time, it was realized that a great number of the cases being treated by the social service department could be better understood and considerably helped by suitable occupation in a proper environment. In 1914, when unemployment reached its greatest height in this country, it was impossible for the average patient who did not adjust easily to his environment to secure employment. Then, too, employers, like most other people, give little consideration to the mentally handicapped, so that an occupational department seemed imperative both from a therapeutic and economic standpoint. In January, 1915, such a department was established as an experiment. An experienced occupational therapist was secured to direct this work who had organized and directed occupational therapy at the Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore. Within a short space of time, an assistant was added to this staff and still later another worker was engaged whose chief duty was the securing of suitable work for these patients. At the conclusion of five years work of this department, there were twelve people employed as instructors and in various other capacities. At all times the patients have received in pay all money from sales of articles made by them above the cost of materials. As these patients were for the most part economically dependent the value of this financial aid served as a stimulus in this therapeutic work. There have been about 400 cases treated in this department since its establishment. Its aid in recoveries and re-establishment of the individual alone has made it a valuable asset to the society. An average of 22 patients have at all times been occupied in the department many of whom were partly and some wholly, self-supporting and still others were suitably located in positions outside. The physically handicapped have also been treated and special work was done for a time with certain groups who were unable to leave their homes.

Starting as a special war-time activity, the occupational department began training classes for occupational therapists and during

this period and to date has trained more than 250 people, a number of whom served in the late war as reconstruction aides in this country and overseas. Several are now filling positions as occupational therapists scattered over the country in general, state, and government hospitals. Similar centers for the training of occupational therapists have followed in other cities as directed work in occupational therapy is by no means limited to the psychiatric problems.

In 1918, the director of this department was also made director of occupational therapy in the Illinois state hospitals to organize the work in these institutions. The pupils in training for occupational therapists had their practical training in the state hospitals which furnished over 3000 days work to the state. Recently the state has taken over this training class work entirely as well as the director of the department.

That social service and occupational therapy have each a large field for work with mental hygiene organizations in the larger cities is an established and demonstrated fact. Rather decided types of psychoses, especially of the dementia præcox group can be effectively guided in the community for the most part as partly or fully self-supporting citizens, thereby causing a considerable saving to the state. Many of the so-called "nervous invalids," particularly the psychopathic and psychoneurotic types, who are frequently the chief parasites of charity can also be fairly well established on their own resources by such aid.

OTHER PUBLIC SERVICE.

The society has never functioned to any great extent as an organized body for power and influence in formulating or supporting favorable legislation for the dependents with which it deals. Individuals and small groups of members, however, have worked for certain measures relative to laws, institutions, and general local improvements in a rather effective manner. Among their efforts in this direction was a survey made in 1909 of the surroundings and treatment of mental patients in Chicago and Cook County prior to commitment which lead to certain improvements. During that same year they supported the passage of an act creating a State Board of Administration and State Charities Commission in place of a State Board of Charities and local com-

mittees for each state hospital. In 1911-1912, an Act authorizing the establishment of an institution for epileptics and in 1914-1915 an Act authorizing the commitment of the feeble-minded were passed having the support and influence of different members of this organization. In 1912, motor car transportation of women patients from their homes in Chicago to the hospital was furnished, replacing the usual police patrol and policemen. In the same year, it supported bonds for the building of a modern psychopathic hospital to replace the Detention Hospital which had only 45 beds, but frequently housed from 65 to 125 patients the night before court day each week. In 1913, full interne service for the Psychopathic Hospital was established previous to which time there was a 10-day service of internes from the Cook County Hospital. A commission of two physicians was appointed in 1912 to deal with mental cases in court replacing a jury of six men or women, one of whom was a physician. A full time resident was secured for the psychopathic hospital replacing the county physician who was appointed for half-time service. A ruling of the county board and county judge was secured allowing patients to be brought directly to the hospital for examination instead of being held in police stations as had been the custom.

FUTURE WORK.

In view of recent developments within the organization better work along the lines already suggested will be continued. While many of its activities in the past have been limited to Chicago much has been done in the state as well as some notable country-wide benefits from special activities. All future work it is hoped will be state-wide and there is no limit to the many avenues for work along mental health lines that such an organization might undertake. Different states might present many and various problems to be worked out that some other state would not consider so urgent. Then, some of the objects might be completed and others perhaps assumed by the state itself. There is much, however, always remaining to be done as is the case in all of the special branches of medicine which are rapidly changing fields. One most healthy advantage of a society for mental hygiene is its independence and this if properly organized and directed can make it a powerful factor in any state for much constructive work particu-

larly in promoting remedial legislation and bringing to the attention of the public and proper officials the necessary facts about the prevalence of mental disorders and defects and the financial and other needs of the institutions for these people.

One is overwhelmingly impressed in the field of mental ill-health, wherever he may be, by the ignorance, prejudice, and fallacies existing relative to this subject, when it is one of the most serious questions confronting public health to-day. We have practically erased the word "lunatic" from the wording of our laws and from the names of our hospitals, but we have done little towards eradicating from the minds of many people the belief that there are "lunatics" still in our hospitals and that there is a connection between the moon and the mind and other equally absurd notions quite prevalent to-day. This state of affairs was excusable perhaps not many years ago, but with the accumulating knowledge and reliable facts of recent years in reference to the causes, prevention, and treatment of these different disorders, there is no justifiable reason why the existing agencies in this field should not be taking time by the forelock and giving the community the benefit of this knowledge as is the case with other illness from the public standpoint. These facts are of little value so long as they are locked in the books and in the minds of those with this knowledge.

Educational and propaganda work in mental health will be one of the chief features of the future activities of this society, education, not only in the popular field relative to the public at large, but also applied to the many social problems that modern mental medicine has established as worthy of consideration and carried to the very home of education—the school. Whatever work is done of an educational nature must be continuously sustained if results are to be expected and many years will be necessary to make an impression. A piece of work now being undertaken in Chicago and throughout the State of Illinois is promoting the establishment and effective operation of public mental health centers and in this connection we are planning to reach the public by way of conferences from time to time when lectures, exhibits, literature and newspaper publicity dealing with the different phases of mental health will be available. My experience so far has been that if people are acquainted with reliable facts there is

a hearty response for the betterment of that community's health as related to the local problems. These centers will, of course, do clinical work and several requests have already been received from leading cities of the state for this assistance.

It is being more and more recognized in any campaign for better health that the tendency is to turn back to childhood to effectively deal with prevention along special lines. In no other realm of medicine has so much evidence been produced of late to show the importance of attacking mental disorder in childhood. With this in mind our efforts in these centers will be partly directed towards better mental health for the normal child as well as the atypical and unusual types so commonly found. There are other activities that one might suggest. The ones mentioned present important problems for some future years' work along with the many and various questions arising from day to day with an organization so long established and favorably known in a community.

The society is fortunate in having the co-operation of the Department of Public Welfare of Illinois through those officials whose work is so closely related to that of the society. Illinois is doing things beyond its institutional walls, and future plans speak well for still better and greater work in this broad field. Surely a state housing more than 17,000 insane alone, with an annual admission rate of 7000 patients, cannot fail to impress its citizens with the importance of the work of an organization dealing with these and other mental problems at the different levels from which they arise.

(NOTE.—Space will not permit naming the many people of Chicago and Illinois who have contributed time and money to the support of the Illinois Society for Mental Hygiene. It would seem appropriate, however, to mention those people who formed the nucleus of a group intimately connected with its founding and support during this period. Among these are Miss Jane Addams, Dr. Henry B. Favill (deceased), Dr. Alice Hamilton, Dr. Sydney Kuh, Miss Julia Lathrop, Mrs. Anna Hamill Monroe, Miss Mary Rozet Smith, Miss Adelaide Walsh, Dr. Sidney D. Wilgus, and Mrs. Mary H. Wilmarth (deceased).)

The practical work of Miss Elnora Thomson, the first nurse employed and later Executive Secretary and Superintendent of the Society has made possible this report. The work in occupational therapy was carried on under the immediate supervision of Mrs. Eleanor Clarke Slagle.)

WHAT AN ADEQUATE MENTAL HYGIENE PROGRAM INVOLVES FOR THE STATE HOSPITAL SYSTEM.

By GEORGE M. KLINE, M. D.,
Commissioner, Department of Mental Diseases, Boston.

It is quite apparent that the need for increased activity in relation to mental disease and defect is generally recognized, as is evident in new and improved legislation being passed and much larger appropriations made for the better and more scientific care of patients. The initiative for this change may quite properly be credited to a rather small group of persons and often their recommendations and requests meet with much opposition. It must be conceded that gross misconceptions regarding the fundamental facts of mental hygiene exist in the minds of the laity. "Peculiarities" which in many instances may indicate mental disorders have no apparent connection in the minds of many, including physicians, with mental disease. It is both interesting and significant to note in this connection that the more common causes of mental disease as given by the laity in connection with patients sent to our state hospitals remain quite unchanged. Such causes as "love affairs, family troubles, overwork, worry, religion," etc., are still commonly used.

Only those who have been long associated with mental patients and their problems appreciate the difficulties which they encounter in the community, before hospital residence, and after their return to the community. Because of this stigma, many otherwise intelligent persons avoid seeking early help for themselves or their relatives until more serious conditions develop. For this reason many deny facts of heredity that have a bearing on mental disease. In securing employment for discharged mental patients, the psychiatric social worker is often beseeched to conceal all facts pertaining to a mental breakdown because of the very grave difficulties which they must otherwise encounter. The lack of information relative to the terminology used in psychiatry is added evidence that mental disorders are meaningless to the general

public. Even the more common terms such as "senile dementia," "feeble-mindedness," "softening of the brain" are strangely misunderstood. To a large majority of the people, including physicians, definite mental disorders are practically meaningless and appear to be confused with temperamental difficulties. A recent article by Donald A. Laird, entitled "Does there exist a need for a program of Education in Mental Hygiene?" indicates very clearly the status of society to mental hygiene knowledge, and perhaps explains part of the opposition met in efforts to bring about changes in our laws.

Only recently a special recess committee of the Massachusetts legislature named to investigate conditions prevailing at state institutions, calling special attention in their report to the enormous sums spent annually for the maintenance of state institutions, made this encouraging comment. "The sum spent for research into the causes of disease and conditions resulting in the need of these institutions is negligible. The committee believes that research work in the field of mental disease and defect should be pursued aggressively on a much larger scale. In this way only can it be hoped to make available information that will prevent, in the future, a heavier burden upon the state."

Unquestionably the startling and unlooked for results of the neuro-psychiatric examinations incident to mobilization, the work of the neuro-psychiatrists throughout the war, and the number of mental cases among the war risk beneficiaries have served to direct attention to the importance of psychiatry and the great need for a mental hygiene program.

It is through the state hospital system and, more especially the component part of such a system—the state hospital—that information regarding the causes, treatment, prevention of mental disease and mental defect is readily gathered.

For this reason the state hospital is the logical center from which information regarding mental hygiene should be disseminated. The state hospital, especially since the advent of out-patient clinics and psychiatric social service work, can no longer afford to be a thing apart from the community. It has much, in fact is under definite, obligation to contribute in every possible way to a mental hygiene program. Years ago in a report dealing with the best method of providing for the insane, made to the Massachu-

setts legislature, this obligation of the state hospital was recognized, as is evident from the following statement :

"It should be a center of instruction and counsel in mental hygiene, prevention of insanity and after care of discharged patients. The poor of the district should be encouraged to seek its advice, and granted free consultation while they may properly remain at home. An out-patient service similar to that of the general hospital should be maintained. There should be cooperation with local charitable agencies in ascertaining home conditions and in the endeavor to better or change the unsuitable. Thus incipient mental disease would be brought to notice, dangerous tendencies discovered in time to erect safeguards against violence and public confidence won."

From the foregoing it would appear that the work of the state hospital system in fitting into a mental hygiene program is largely in the direction of education. This service is now very largely extended into the community through out-patient clinics and psychiatric social service. In Massachusetts, 14 state hospitals have out-patient departments, and clinics are held under the auspices of the hospital authorities in 28 cities and towns. In this way, this service is extended to practically every community of the state. The functions of these clinics and the work of the psychiatric social service departments have been dealt with in previous articles. The Department of Mental Diseases now employs a director of social service who supervises the work in the hospitals throughout the state. At the present time 19 social service workers are employed by the hospitals and in addition nine student workers. Special mention might be made of an act recently passed enabling the presiding judge, in his discretion, in order to determine the mental condition of any person coming before any court of the commonwealth, to request the assignment of a member of the medical staff of a state hospital to make such examination, without charge, as may be deemed necessary. It is gratifying to note that more and more requests for this service are being made. It is a permissive act which it is hoped will speed the day when a competent psychiatrist will be attached to each court.

Still another act of vital importance to an adequate program in the handling of the feeble-minded problem has been passed. It requires the school committee of each city and town to ascertain, under regulations prescribed by the Department of Education and the Department of Mental Diseases, the number of children three

or more years backward, and where ten or more children as so retarded, shall establish special classes.

Provision was made for the establishment of free clinics and a registry for the feeble-minded. In accordance with this legislation, travelling clinics in connection with the schools for the feeble-minded, in charge of a psychiatrist assisted by a psychologist, social service worker and necessary clerical help, will aid in the mental examination of such groups of retarded children as are reported. Supervision by a central authority of neglected feeble-minded in the community is yet to be provided for as an important phase in the handling of the feeble-minded program.

In disseminating knowledge relative to mental hygiene, the opportunity should not be overlooked by the state hospital to not only invite the general practitioner to attend the daily staff meetings but, failing to attend, to send information regarding the diagnosis, prognosis and present status of each patient that he has committed or advised to undergo hospital treatment.

Too frequently is noted the apparent indifference of the general practitioner to mental patients. Their interest can readily be gained if they are kept advised regarding their former patients. In this way their cooperation in after-care work can be had the easier, and a friendly attitude toward the institution engendered.

The startling lack of knowledge in psychiatry on the part of the medical profession presents a most serious problem and unless active measures are taken to remedy this defect, not only may little advance in mental hygiene be hoped for, but the standard of care of patients in state hospitals will inevitably suffer and eventually amount to little more than custodial care.

The crying need of state institutions is for trained men. The relative importance of psychiatry to other branches in medicine is not difficult to establish. Not only should every medical school be required to give adequate training, but it should be obligatory for every candidate for medical degree to pass an examination in psychiatry.

The state hospital system, through the establishing of psychopathic hospitals, should be a necessary adjunct to the medical school in the teaching of psychiatry. This interdependence of the state hospital system and medical school is better illustrated by an arrangement under consideration in Massachusetts between the

Harvard Medical School and the Psychopathic Department of the Boston State Hospital, which will become a separate institution in the state hospital system, under the Department of Mental Diseases.

The director of the Psychopathic Hospital, under the contemplated arrangement, will be Professor of Psychiatry at Harvard Medical School. A similar pooling of interests is also under consideration whereby the professor of neuropathology would direct the scientific research laboratory work of the Massachusetts Psychiatric Institute. The psychopathic hospital, receiving patients for intensive study, care and treatment, with opportunities for laboratory research work in neuropathology, would then occupy a position in the medical school as important as the medical, surgical and other clinics.

The functions of these clinics, as aptly defined by Kraepelin, are attendance on the mentally sick, instruction to students, and places to which criminals suspected of mental disturbance may be sent for observation, the dissemination of medical views on social questions, and correction of existing prejudices regarding insanity, to serve as a connecting link between the larger remotely situated institutions and scientific research and scientific investigation of all problems connected with the study of mental diseases.

It is obvious that when medical schools require graduates to be as well informed in mental diseases as is now required in the practice of medicine, many mental disorders will be considered at their source by the general practitioner.

Accordingly there should be a desire and willingness on the part of a state hospital system to cooperate with medical schools in the teaching of psychiatry. The need of trained men is so great at present, that it is believed this association might very properly exercise its influence in every possible way and support every effort to the end that an adequate course in psychiatry be given in every medical school.

DISCUSSION OF PAPERS BY DRS. SALMON,* ABBOT, TRUITT AND KLINE.

DR. BLUMER.—I am not on my feet to open the discussion of these papers. The questions before us in regard to mental hygiene may be seriously

* Dr. Salmon's paper, "The Practical Aims of the National Committee for Mental Hygiene," was not furnished for publication.

debated by others. Charles Lamb once said it was a mistake to look at both sides of a question because it tended to confuse the mind.

What I have at heart to say is in the way of a personal tribute to one of the speakers, and I think I may do that without seeming in the least degree invidious to the other gentlemen who have contributed to our entertainment this morning.

About fifty years ago, as some of the older men may remember, there lived in New York a distinguished though by no means a scholarly surgeon, whom I will forbear to identify further than by saying that he went to Europe, and while there was lionized in London. In a great hospital of that city he was asked to perform an operation before the students, and when he came back to New York and told his class about the honors he had received in the metropolis, he said expansively: "Gentlemen, that was the proudest moment of my life when I felt that the eye of the *vox populi* was upon me." I wish to apply that delicious utterance and avowal to my friend Dr. Salmon, or rather to myself, through him. Dr. Salmon, as very few of you here can know, since I did not know it myself until a few years ago, did me the honor to attend my lectures in the Albany Medical College somewhere in the nineties, taking part in the very inadequate instruction in psychiatry which obtained in those days, and listening very attentively to the 10 or 12 lectures which it was my privilege or task to deliver. He also went with me on one occasion through the wards of the State Hospital at Utica, learning everything there was to be learned about clinical psychiatry on that single visit. It always delights me whenever I hear Dr. Salmon and see him in the spot-light on occasions of this kind, since it ministers to my own vanity and self-esteem. It really is extraordinary that a man having had so little training in psychiatry, as a student, in those days of jejune teaching, should have developed into what he now is. It fairly beggars imagination to reflect what a still more wonderful man he might have been if he had been properly trained when I was responsible for that part of his education. Today I count it a great pleasure to be here as Gamaliel now sitting at the feet of St. Thomas.

DR. KILBOURNE.—I am very glad indeed to have met Dr. Salmon with his smiling countenance, because I can go home and tell my people in the office that he is a very nice gentleman.

I have several threatened strikes from my office force and others, who thought they were rather imposed upon when asked to make up the statistical sheets that are required, but when we finished with the compilation of these statistics I took them to the office force and said: "Look at that; you helped do this, and we are going to raise your wages! So they can thank you for that. Among these statistics was one occupying several pages, relating to recoveries in state hospitals. Recoveries in state hospitals depend somewhat on the "follow up." One of those institutions had a recovery rate of 48%; another, I believe, claims 70%. If you will get a dentist; put in an X-ray machine; get a good pathologist; have a good

follow-up system, your recovery rate may jump 75 to 100%. It encourages us to know this.

DR. COPP.—I think we are all conscious of a growing interest in psychiatry, evidenced by the establishment of psychiatric clinics, such as at Ann Arbor, Boston, Johns Hopkins, and the latest in Iowa. Probably within a few years there will be at least a half score of such fully developed clinics in university centers. The better teaching of psychiatry in medical schools will result. I cannot help feeling that the activities of the National Committee for Mental Hygiene and the local activities of mental clinics have contributed largely to the increase of interest in this subject. I wonder if we realize how the National Committee for Mental Hygiene works. I did not. It was my privilege to go with Dr. Salmon on one of his many trips last winter; it was to a nearby state. When we left that state I felt that the two days' work meant a psychiatric clinic in connection with the State University Hospital, a chair in psychiatry in the State University and psychiatric social service work throughout the state. This is only a single instance of what is being done again and again by the National Committee. I was greatly impressed by the ideals presented in this way. The influence exerted is wonderful.

DR. BRUSH.—Once I was young but now I am older. I have seen in the course of more than 40 years work in psychiatry many efforts made to improve the condition of things from the outside of the institution. I have seen organization after organization formed for that purpose, and always they were of the critical kind and the kind of criticism that was destructive—not constructive and helpful. Now comes along the National Committee for Mental Hygiene and they turn around and are making criticism that is helpful and instructive, constructive rather than the opposite. Very few of those of us who are, or have been, connected with hospitals, realize what the future results will be if we cooperate heartily with what they are doing. When a man comes around and tells me my back yard is in bad shape and has a general air of dilapidation, I feel that perhaps he might just as well be minding his own business. But when he tells me there are certain things that would make the place look more inviting and that he has seen somebody else do so and so, how much more readily I accept it. I think there is nothing that has come to this country which has been, which is going to be in years to come, of greater advantage than the helpful criticism of the National Committee for Mental Hygiene. Perhaps being on the outside I can say things I would not feel like saying a few months ago.

I was interested in what Dr. Kilbourne said about recovery rates and the "follow-up" system. I think we all realize, however, that some of our patients who recover do recover at home. There is also a "follow-up" in the other direction. Some of our patients, who have been discharged "recovered," if we follow them up, are found to have had a very bad relapse, and we should take them out of the "recovered" column. I have written.

I think, 28 annual reports, and except for a general statement of the operations of the institution for the year, I have almost always refrained from putting tables in the reports; I do not think they amount to very much. Many wish to make the recovery rate as high as possible. I have known of a patient going to his home and then to another hospital for some reason, who quietly dies in the second hospital and the first hospital escapes the necessity of putting that death in its column of statistics.

After all what difference does it make, if we are doing the best we can, if we are seeking light in all directions, whether our rate is 48 or 45, or even 19. Possibly the latter is showing just as good work as *X*, the rate of the man who brings the recovery rate up to 48.

DR. ALBERT ANDERSON.—I would like to say a word on this subject as an encouragement to some state that has not tried out this mental hygiene movement. I think I interpret the cause of Dr. Salmon's great success in this movement—because he has put in it a spirit that will never die; the spirit that we find in the life of Dorothea L. Dix. He has a love for the work that is inspiring.

We have had an organization in my state and we have that spirit that he generates in his office. We have been having a survey made and we find the surveyors have his spirit. I am glad to have a part in this movement. At our hospital we put a man in the field to canvass on the subject of mental hygiene, in schools, hospitals, etc., and we have informed our people in a practical way. We were not aware at the time how much we were doing in informing the people and promoting education along these lines, and I am glad to report that we are not having the same difficulty in getting money for our institutions. I feel that we are at the dawn of doing great things, and I want to encourage all the states to start this work in cooperation with the National Committee. We can do more than we dream of. We had to stop our work on account of the war. At the last meeting of the state society, we elected new officers as president and secretary and they have failed to keep the work going. The secretary was drafted into service and the president has not called a meeting since. We will soon start this work again.

DR. H. W. MITCHELL.—The meetings of our association today were arranged for the specific purpose of presenting to the members some idea of the activities of this great national movement, which has accomplished so much in its short career. Its influence has been felt upon state organization and hospital management, and much has been accomplished for the welfare of patients. Its activities have affected national and state organization, the army and navy have adopted recommendations of the Mental Hygiene Committee and have been materially aided during the war period by the advice of its members, most of whom are active members of our own association.

It affords me pleasure to mention the statement of the Surgeon General of the United States Army, Dr. M. W. Ireland, to whom notification was

sent by me as secretary, informing him of his election as an honorary member of our association. In his letter of acceptance he stated that he felt honored by the election, and while he did not feel that his services made any claim for such recognition upon our association, he had been much interested in our work which had been made pleasant for him because of the activities of our members. He referred to the Medical Director of the National Committee in the following words, "Col. Thomas W. Salmon, was chief of the Psychiatric Service in the American Expeditionary Forces, and it was such a pleasure to do all that I could to carry out the various sane recommendations which he always presented for the welfare of nervous and mental cases." We feel that the work of the National Committee and our own association are, in a measure, complementary to each other and that as individuals many of our members can accomplish in one association what they could not well undertake in the other. Certainly the members of our association can feel that the National Committee has always when called upon done everything in its power to promote the interests of psychiatric work in any of its many fields. The work of the National Committee has not stopped, it is going to spread and I predict that it is destined to be one of the great national influences for the betterment of mental health and the promotion of psychiatric work.

Now while yielding public tribute to the men who are making this work possible, it is well that we should turn back for a moment and recall the origin of this movement. My memory goes back to a day not far distant when the Mental Hygiene Association walked into the office of the Danvers State Hospital, in the shape of a young man bearing a manuscript, and what is of more vital importance carrying the germ of an ideal, the development of which we are seeing to-day in the work accomplished in the pursuit of that ideal. It is most fitting that we should pause for a moment and, recalling the origin of the National Hygiene movement, give credit to its originator, Mr. Clifford W. Beers.

DR. OSTRANDER.—Some 30 years ago when I commenced work in a hospital for the insane, not only the patients were segregated, but the physicians were segregated as far as their relations with outside things and the outside world was concerned. The result was suspicion on the part of the public and the press, and general trouble all around. I do not think that the state hospitals, as a rule, have taken pains enough to advertise themselves—what they are doing. I do not hesitate to spend the institution's money to give luncheons to organizations made up of prominent men like the Rotary Club, the Kiwanis Club, and at those luncheons to talk about matters such as have been presented to-day. The result is very gratifying.

The National Committee for Mental Hygiene has not invaded Michigan as yet, but the hospital with which I am associated has been interested for the last four years in carrying on this work to a limited degree but in a degree that gives some satisfaction; just such work as Dr. Salmon has outlined to-day. We do not take the credit, however. I got the inspiration at the convention in New Orleans, in the papers I heard from Dr. Salmon

and others. I wish some one would tell me how to get the doctors interested; they are not interested in this work. Among the hundreds of cases presented at the clinics I think I can name on my fingers all the cases that have been referred to us by physicians. We started out to make interesting programs at our staff meetings and to invite the local physicians to attend these staff meetings. Two or three came for awhile and that ended it.

DR. SALMON.—Dr. Williams has raised the question of the relation of psychiatry to neurology, especially in the management of university psychiatric clinics. I realize that there is a good deal of force in what he has said about the importance of giving neurological patients adequate representation in the wards of such clinics but I cannot help feeling that in many parts of this country the difficulty has been quite the other way. Neurological patients, whose disease does not express itself in disorders of conduct are, except for their chronicity, just as welcome to everything that general hospitals have to offer as any other kind of sick persons. With mental cases, however mild, exclusion is usually absolute. I can never forget what I have seen many times in Philadelphia which many persons will hold to be the neurological center of the United States. There, in the mental wards of the Philadelphia General Hospital the medical advances of the last 60 years have made no impression. Any new knowledge that we possess regarding the treatment of mental diseases exerts no influence whatever upon the 2700 patients in that department. In another department of the hospital, because their disorders do not involve special difficulties of management, organic neurological cases are to be found under general hospital conditions. It would be foolish for any one to advocate teaching psychiatry except in the closest relationship to the teaching of clinical neurology and, of course, neuro-pathology is as necessary in the foundation of psychiatric teaching as of neurology, yet the principal need is not for more beds and more facilities for teaching clinical neurology but for providing special departments of university hospitals to which mental cases can be freely admitted and thus enabling medical students to secure their knowledge of mental medicine in the same atmosphere of science and humanity as that in which they receive their knowledge of general medicine.

Dr. Ostrander's question as to the methods by which the interest of doctors may be diverted to mental disorders is a difficult one. It seems to me that there is little hope of doing much after the period of instruction in medical schools. On the other hand the experience of the army showed that where mental diseases can be treated under conditions similar to those of general hospitals, doctors lose all that curious feeling that psychiatry is a subject entirely alien to medicine and find many problems in the psychiatric wards which are quite as interesting to them as those in other departments of the hospital. It is likely that the extension of psychiatric wards and departments in general hospitals may change the viewpoint of physicians but, in my opinion, the hope of the future lies in the adequate teaching of clinical psychiatry and mental hygiene in the medical schools.

MEDICAL AND SOCIAL ASPECTS OF CHILDHOOD DELINQUENCY.

By SANGER BROWN, II, M. D.

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The question of delinquency and behavior disorders of early childhood is one which must attract the attention of everyone interested in the welfare of the community. Knowledge about matters of this kind has come about gradually in the past. It has not been for very many years that we have considered delinquency in adults as attributable to any particular mental background, so it is not remarkable that our knowledge of these conditions in children is incomplete in many respects. Of course no one can fail to appreciate the importance of understanding the delinquencies in childhood from a social point of view. There is every reason to believe that adult law offenders and delinquents may be recruited, to a great extent, from the ranks of these delinquent children. It becomes important, therefore, to study the condition during its developmental period in childhood in order to understand its origin and to see what remedies may be applied. If such cases can be saved from delinquency during the developmental period, and their lives turned to good account, it is at once evident how much suffering is spared the individuals involved, and how the state is relieved of a great social burden.

There is also considerable likelihood that much scientific knowledge as to the development of mental disorders of adult life may be gained by the study of these conditions in children. Most of our knowledge of such conditions heretofore has been gained through the study of symptoms as observed in adults, and it is true that the past twenty years has shown great advances in our understanding of such states. But in some respects we have perhaps accepted certain dogmas a little too readily. For example, there is the matter of personality. We have been inclined in the past to accept one's personality as a fixed and rigid thing; but is it not possible—or in fact, probable, that the personality which we see in the adult is the product of a combination of circum-

stances beginning in the very earliest years of childhood and developing in favorable or unfavorable directions according to the host of influences which are brought to bear at that time. Then, there is the question of heredity. Interest in the nature of mental reactions was at one time largely centered in the question as to whether the condition was inherited or not. But we are now far away from that rather fruitless problem, and intimate knowledge of the daily home life of children may readily indicate how the sensitive mind has developed tendencies from bad environmental conditions which might later in adult life be wrongly attributed to heredity.

For purposes of orientation a few remarks may be made as to how such a study is being carried out in a probationary school in New York City. The authorities of the public school system of New York have seen the establishment of separate ungraded classes, of truant schools, and later of the probationary schools; but with a keen appreciation of the needs of a fuller understanding of the question of school truancy and delinquency, they have desired that an inquiry be made into the question of causes and origins. With this in view, they have invited the National Committee for Mental Hygiene to make a study of this problem in a probationary school, the object being to have a survey of such a character as will throw light on the underlying causes of delinquency.

A physician, a psychologist and a social service worker have been appointed by the National Committee for Mental Hygiene to make this study. The probationary school is on the East Side of New York and it accommodates about 200 boys who remain in the school up to the age of about 15 years. The school is known as a probationary school and the boys are sent there in order to receive special instruction and observation in small classes. They come from the regular classes in other schools, and as a rule it is found that a faithful effort has been made there to carry on their education in the usual way. These boys, therefore, have generally shown delinquencies, conduct disorders and maladjustments of rather marked type. If they were not sent to this probationary school, it would be necessary to send them to a truant school where they would be in residence. This fact is stated in order to indicate that the more serious types are under observation

here, although the delinquency may be rather less serious in type than one would encounter in the Children's Court. In approaching this subject it will first be of interest to record some of the misdemeanors of these boys as one learns of them from lay sources.

Truancy is a very common cause of difficulty, although it must not be thought that any of these delinquencies exist singly. That is, truancy is very likely to be associated with other forms of misconduct, such as petty thieving, disobedience or untruthfulness. However this may be, many of the boys are persistent truants, staying away from school, playing in the street, going to the movies, or playing in the park day after day, or even week in and week out, until brought to account by the parents, police officers or Bureau of Attendance. Then, there is petty thieving in many forms. At times boys only take things from their own homes—small amounts of money or some salable objects; but much the most common form of thieving, especially with smaller boys, is to take fruit from stores on the street and from peddler's wagons. This leads to taking minor objects from inside the stores, and once this develops, the thieving tendency is fairly well established. Then, too, small boys organize at times in groups of three and four, and on not a few occasions hold up another boy on the street, go through his pockets and take what little money he may have.

Disobedience is, of course, very common. Many of these boys are quite beyond the control of their parents; they do much as they please, and such discipline as is attempted is of no avail. This leads to loafing and vagrancy, and especially staying out in the streets at night. Not infrequently during the summer time they stay out all night, sleeping in cellars or vacant lots. Gambling in a petty way is harmful with these boys. The boy finds himself without lunch money, and may either go hungry or steal from a grocery stand or peddler's wagon because he has lost his lunch money through gambling. Or a boy may find that he is a few pennies ahead and keeps himself in cigarettes which he can buy for a cent apiece in some places.

A very unfortunate development in these cases is what may be termed an anti-social attitude of mind. After they have been involved in a few delinquencies and perhaps have been taken to Children's Court, they are no longer frank, honest and truthful in attitude; they become suspicious, reserved and on the defen-

sive in their statements. Unfortunately, this condition is quite frequent. Such an attitude of mind should not be looked upon as an expression of the inherent character of the child, but as something which has come about as a result of experiences which he has undergone.

With an appreciation of these general types of conduct disorders, questions at once present themselves as to their origin. Are these troubles dependent upon the physical condition of the child? Is it malnutrition or improper food which is at the basis of the trouble? Or is some more definite physical disorder to be blamed, such as enlarged tonsils, bad teeth, defective vision, or improper breathing due to adenoids? Or does the disorder rest more definitely in the mental sphere, possibly on basis of unrecognized mental deficiency? Or is the disorder one of personality rather than of actual mental defect? Then, too, one asks whether the trouble arises not from the child itself, but from the environment such as would exist with improper home training or unfortunate home or neighborhood environment? Finally, are there very definite mental conflicts in each case determining the character of the symptoms and bringing about the unfortunate results?

In attempting the solution of any of these problems, information must be gained from all sources. One desires an intimate knowledge of the family life and home influences, of neighborhood environment, of school life, and a record of the developmental history of the child as well as a record of his behavior. Examination of the boy himself probably contributes more than any other one thing toward understanding the case, but this is inadequate without all the other available sources of information.

NERVOUSNESS AND DELINQUENCY.

One finds a great variety of things which seem to be of importance in causing delinquency and it is rather difficult to group these causes under general headings. However, this is possible to some extent and so an effort may be made to present some of the findings in this way. One general condition, therefore, which appears to be a cause will be considered first; namely, the presence of nervousness or nervous symptoms as leading to delinquency in children. A fair number of the children show nervous symptoms, sometimes mild and temporary; sometimes severe and of long standing, and these symptoms are of various types.

One of the most common symptoms observed is disturbance of sleep. This may be very mild amounting only to restlessness and fears at night, or it may be fairly severe, in which case somnambulism seems to be especially frequent. Of course these symptoms do not exist alone and they are to be taken as indications of an underlying nervous state. We find that such children are quick tempered, irritable and lacking in normal emotional control, so that they show impulsiveness in various ways.

Another very frequent symptom of nervousness, especially in the smaller boys is overactivity. A few marked cases of this have been seen in the small boys, accompanied by irritability, ill temper and mischievousness. Such boys show great restlessness; they are up early in the morning and stay out very late at night—it being impossible to keep them in control. They are often thin and ill-nourished. Two such cases in this school have these symptoms of overactivity to such an extent that they need special medical treatment. With this physical excitement some of the children appear to show a great deal of mental excitability also, telling all sorts of fantastic tales, although this in itself can scarcely be considered unusual since it is seen so frequently in normal children.

Then, cases are seen which are quite the reverse of the above. They are inactive, languid, do not take part in games, and appear to be lacking in normal, nervous vigor and energy.

Very frequently one sees boys with various physical complaints comparable to those which one sees in adults—the so-called neurotic symptoms. Complaints of stomach trouble, inability to eat certain things, headaches, and complaints of various pains are often encountered. While such complaints cannot be overlooked from the physical standpoint, it is not difficult very often to demonstrate that these symptoms are of mental rather than of physical origin. A few concrete examples of nervous symptoms associated with delinquency may be given.

A small boy was admitted to the school some time last year, the record being that of a serious disciplinary case. He was frequently late for school, he was noisy and disturbing in the classroom, he was constantly the center of fights and disorder, and was inattentive in his studies. At this school the same difficulties were found; he was always whistling out in class, getting into difficulties, and could not be kept quiet. His mother reported that he was disobedient, out on the streets most of the time and could not be kept in the house. He was quite out of control at home as well as at school, so that his problem was somewhat difficult.

On examination he was found to be a woefully thin, ill-nourished child with an exhausted appearance and with a rather sad expression which seemed to indicate a great deal of unhappiness. He looked like a little old man, and because of his ill-nourished state it was thought at first that this must be due to some physical disease, although examination revealed no disorder. It was found that this boy came from a very unsatisfactory home in a bad neighborhood. His father and mother did not seem to feel much responsibility for him, and so it was thought that his condition was to be explained on general home situation and environment. Moreover, the boy has a brother who is a chronic truant.

However, a much more definite factor was determined. It was learned that this boy, after school, was working for long hours carrying coal and other supplies for a grocer. He carried things which were altogether too heavy for him, and at times he would be physically exhausted. This had been going on for many weeks. This work was discontinued when the situation was understood, and at about the same time a lunch with cocoa was introduced into the school. With this a remarkable change was soon noticed in our boy. He grew less irritable and restless, his self-control grew better, and as time went on all symptoms improved. In three months he gained 6½ lbs, and from the physical standpoint looked a different boy. The others no longer teased him. He no longer caused trouble in the class room and his teacher reported him as a very nice boy indeed. He was found to be warm-hearted and kind, and he showed a number of excellent traits of character, being popular and well liked by the others.

This boy, then, was one of the overactive types of nervousness described above. From being overactive and irritable he became quiet and composed and his general delinquent tendencies subsided. The boy had been ill nourished and overworked with resulting nervous symptoms, and while, of course, the general condition of home and environment were of some importance, they were factors of much less importance than the immediate situation. Here is a case, then, of delinquency associated with nervousness in which a fairly definite cause was found.

Another similar case may be mentioned here.

A boy of 10 years was entirely out of control both at home and in school. He was constantly thieving, gambling, was frequently out all night, was very active and mischievous, and was finally taken to Children's Court on the charge of highway robbery, he, with a number of his young companions, having held up an older boy and taken a watch from him. Without going into all his delinquencies it may be said that the basis of the condition was found to be over-stimulation. He ate with the rest of the family, and the men of the household, who were laborers, put whiskey in their coffee. The child drank several cups of this a day and did not take very much else. He drank a great deal on Sunday—in fact, was often intoxi-

cated, and on Monday morning was ill, as a result, with headache. He was of the overactive type also, and was mischievous and boisterous.

With the lunch and cocoa and with the discontinuance of alcohol he entirely changed; from the pinched, thin faced little boy with a muddy complexion, his expression changed, his color improved, and he, too, gained about 7 lbs. He is now a different boy. One never hears complaints of him. He is excellent in his studies, and there is every indication that the causes of the condition were insufficient food with too much alcohol. He, again, was one of the overactive type, the symptoms being attributable to a very definite cause.

Unfortunately, cases of delinquency can seldom be explained on this simple basis. Such physical causes, however, when they do exist, seem more common in the younger children, and it is always quite necessary to examine the child very carefully to learn whether nervous symptoms may be brought about by an undermining of the general health. These physical causes of symptoms are quite easy to understand, and if our inquiry could cease there, the problem would be a much more simple one. But much more frequently it is found that these maladjusted mental states with nervousness are to be explained on a psychological basis, and the following case is cited as an example of what is often encountered:

This case is that of a boy of good intellect now twelve years of age. He has been a serious delinquent for three years, having been for a term of six months in a truant school, after which, however, his delinquency continued. He has now been at this school for about eight months, and besides truancy he is seriously addicted to stealing—not taking useful or valuable things, as a rule, but small articles from 5 and 10 cent stores, such as cologne, rings, flashlights, rubber stamps, and many other trifling things. With this delinquency he gets in trouble at school. He is restless, gets up and walks out of the classroom, and does not quite appreciate the need of ordinary rules and regulations. The boy has a number of special interests. His teacher says that he shows a great liking for art and drawing. He goes to the Museum, and his mother says he has clay models of Napoleon and Washington in the house which he likes to work over. The principal has noticed that he has an unusually good knowledge of electricity and can discuss fairly complex electrical problems with intelligence.

As well as being delinquent it is found that the boy is of a very distinctly nervous type. At night he is restless, has night terrors, mutters in his sleep about the events of the day, and sometimes he gets up and walks in his sleep and performs a number of simple acts before awaking.

Here, then, is a boy with a fair number of nervous symptoms amounting practically to a neurosis and associated with this is a history of serious delinquency of several years' standing.

The difficulty with this boy was found to be in his sex life. It was learned through a number of interviews that his mind was occupied during much of the time in a very unhealthy way over matters of sex. He learned about this subject when he was about 10 years old from a boy somewhat older than himself, and these boys got into a very unhealthy mental state at that time. This has occupied the thoughts of this boy to the exclusion of other things, causing him to be solitary, self-absorbed and inattentive at school. Indeed the older boy was a sex offender on some occasions with girls in the neighborhood, and while our boy seems to have been too timid and shy to actually commit the same offense, yet his mind was more or less obsessed by all these thoughts. The bad influence of such a state of affairs in a young child can be understood. He developed the nervous symptoms mentioned above, he became solitary, and truancy was not an unnatural outcome. The thieving in his case also rose from the influence of his companion. This older boy stole many simple articles and often gave them to the young girls in the neighborhood. Our boy, of course, did the same thing, and so his impulses to steal developed at that time. The stealing tendency in time seemed to become associated in his mind with these sex topics which were ever present, and so possibly became more deeply rooted than would otherwise have been the case. In this way, then, the various nervous symptoms and delinquencies had a complex psychological origin from difficulties in the instinctive life occurring at an early age. The development has become of quite serious nature, but it is hoped that the situation can be straightened out now that the problem is understood.

Nervous symptoms in children, then, may arise from a number of causes, some quite simple and evident, and some of obscure origin in the mental life of the child. Such symptoms often cause delinquency for a variety of reasons. The child may be merely overactive, irritable and emotional, and these things bring him in conflict with the other children and teachers. The child then begins to dislike school, he becomes a truant and meets up with bad companions. At times also these children with nervous symptoms become solitary and shy and are sensitive. This is because of mental conflicts which occupy the mind to the exclusion of other interests. The remedy in all of these cases, of course, lies

in determining the underlying cause, and then instituting such management of the case as the circumstances warrant. The need of careful investigation of each case from every point of view is, of course, apparent.

DELINQUENCY AND MENTAL DEFICIENCY.

The relationship of mental deficiency to delinquency has been a subject which has attracted considerable attention during recent years. A number of psychological surveys of delinquent school children have been made and similar studies have been carried out in children's courts. Results of these studies are quite well known. It has been shown that a very considerable number of delinquent children are mentally deficient. These studies, of course, have been very valuable since they have led to our understanding of a certain group of delinquents and have called our attention to the fact that mental defect is a basis of conduct disorders in children, in a certain percentage of cases.

Mental defect, however, while the basis of a certain amount of delinquency, does not by any means offer a solution of the problem. With by far the greater number of delinquents, the problem is one of mental maladjustments rather than of mental defect. It is undesirable, also, when mental defect is found, to classify such cases primarily as delinquent; they should be classified as defective, with delinquency as a secondary symptom; adherence to this classification would make the two problems more clear cut. It is true that with a certain number of cases it is very difficult to determine whether or not mental deficiency is present even when all special tests are used, and when a complete developmental history is obtained. Such cases cannot be diagnosed by any one method of examination, and it is often necessary to defer judgment for further observation.

When mental defect is definitely established the case requires rather more investigation than may be generally appreciated. To establish the mental age by psychometric tests is not sufficient. Mental defectives should have a personality study as to their particular mental traits and tendencies, and, of course, environmental influences are quite as important with these cases as with those of normal intelligence. One's recommendation as to proper management of the case must depend quite as much upon the personality

and general mental traits of the defective child as upon his mental age. A case may show considerable defect but be mild and gentle, and therefore, get along well under proper supervision, while another case with much less defect may be irritable and impulsive and therefore require institutional treatment. In making a study of this kind, therefore, these various factors should be kept in mind. The degree of emotional control of the patient should be determined. Some patients are subject to episodes of irritability, are quick tempered and readily get into difficulty with those about them; others are socially adaptable and get along well with others. Some defectives are untruthful, disobedient, and are likely to be delinquent in the moral sphere, while others are strict in such affairs and do not fall into these difficulties unless confronted with circumstances beyond their power of judgment. These various conditions, therefore, must be appreciated in attempting to determine the amount and kind of supervision necessary for mental defectives. Much, of course, depends upon the home and neighborhood environment. Many defectives will probably have to be for in the community and recommendations for the care of individual cases cannot be made unless the above facts are taken into consideration.

When such cases are understood in the home many difficulties may be avoided. Often the parents have no appreciation whatever of the child's conditions. They may either abuse him in attempts at correction or discipline, or they may protect him too much and hinder him from developing such qualities as he possesses. It is evident that special social management in the home is necessary for these cases.

PERSONALITY AND DELINQUENCY.

The question of personality as a basis of delinquency and behavior disorders of childhood is one of great interest. One wishes to know whether delinquencies are indications of a special personality in these children naturally predisposing them toward conduct disorders.

From observations which have been made in the past in our studies with adults we might be led to favor this explanation. That is, we have learned that certain symptoms and certain types of conduct are merely marked or extreme expressions of an in-

herent tendency which had existed previously. Thus, some patients who become markedly depressed and moody on some occasions are found to have always had a tendency in that direction; and some patients who become morbidly suspicious, have been solitary and anti-social for many years. Conduct disorders and delinquent tendencies as seen in adults do not generally develop abruptly, but can be traced back to early life. Observation of such cases have led to speak of definite types of personality, and the symptoms which may develop in these cases can be quite well predicted.

But should not our studies in personality be carried further back than this? Are not these character traits which we see in adults and which may become accentuated to the extent of causing mental symptoms or conduct disorders from time to time—are not these traits, possibly, the product of unfavorable influences in early childhood? In other words, are they not something acquired and might they not have been avoided under different circumstances?

However one may feel about this, one hesitates to interpret mental conditions of childhood, such as conduct disorders and delinquency, on a basis of personality, as that term is usually accepted. It is true that we see children with all the traits and symptoms above mentioned, solitary and seclusive tendencies, emotional conditions, suspicious and anti-social traits—but these symptoms generally appear to be the result of some very definite cause, some difficulty which can be discovered and understood. The child's mind is very sensitive to unfavorable influences, and these influences acting over a long period may bring about the results one sees in later years.

While we hesitate to consider the character traits which we see in children as rigid and established qualities of mind, we nevertheless find in children tendencies toward mental development in very special directions. This does not seem to be so much a question of personality, as the term is generally applied, as it is a question of special interests in certain studies or special abilities in some respects. The majority of school children have similar interests in studies, games and diversions, and they get along very well as a group; but there are always a few in each school who cannot be standardized in this way. They show

special interests in some things such as literature, music or mechanical contrivances, and associated with these they may have too little interest in games or in the usual diversions of children of their age. These types of children are familiar to every one. The rather special qualities of mind which they possess are not harmful qualities in themselves. In fact they may be the very things which are the most valuable, but their presence often makes it difficult for the child to get along unassisted in the ordinary surroundings. Such children may be inattentive in the routine studies. They spend their time on special interests, and in the school they are likely to be punished or disciplined because they do not conform to set standards. This may easily lead to trouble in the school and truancy and delinquency result. The child becomes isolated and solitary. Efforts to oblige him to conform to the usual requirements, unless very wisely applied, increase the difficulty, and one sees the development of a number of secondary unfavorable symptoms from a fairly simple beginning.

An interesting case of this kind where the above conditions appear to be present is that of a boy 13 years of age. This boy is alert and intelligent and has a very active mind. It would seem that he has no serious faults of conduct or behavior, but he has been inattentive in classes and persistently neglectful of his studies, and as a result he has made poor progress in school. It has been difficult in the past to get him to take proper interest in obtaining an education, and he thinks that studying in school is, to a great extent, unnecessary. However, he is not a lazy, indifferent boy; he does not waste his time in foolish ways, but he has a number of hobbies which absorb all his interest and take up much of his time.

This boy is greatly interested in all sorts of electrical contrivances, and, in fact, in mechanical things of any kind. His room at home is filled with batteries, parts of dynamos, wires, electric bells, and such things. He is much interested in a private wireless on a nearby roof, and he reads such magazines as *Motor Age* from which he learns how to build electrical apparatus. The principal of the school has found him exceptionally well informed on practical matters pertaining to electricity. The boy is also somewhat unusual in that he is solitary and doesn't associate very

freely with others, but this is not because he fails to be entertaining or that his companionship would not be agreeable to others. He is isolated because he is intellectually beyond the others in his class, and his interests are at variance with theirs. He does much more general reading than most boys of his age and can give very interesting accounts of what he has read. Occasionally, when he was supposed to be truant he was found to be at home reading books which he had obtained from the library.

But with these interests as stated above he has not made good progress in school. He is an exceptionally poor speller for one thing, and this has delayed his advancement. It would seem that while he has special abilities in some directions, he has a special defect in this respect.

There is little in the above circumstances which need make for delinquency or behavior disorders, but nevertheless the boy did not get along at all well in the regular schools. He was inattentive, was not a good influence for the other children, and the teachers found it almost impossible to make progress with him. He was disciplined a great deal because of failure to do work properly, but he reacted badly to attempts to force him to comply with set standards, and he was spoken of as incorrigible.

This would seem to be an instance of a boy with special tendencies for whom some provision is necessary. The constant friction in a general school was beginning to bring out unfavorable tendencies such as disobedience, slyness and deceit. Things could not but go unfavorably under such circumstances although his innate tendencies were not toward delinquency.

The boy has done much better in a smaller school with small classes and where less rigid requirements obtained. It has been possible to give him some special instruction in the subjects in which he is backward. He is much more amenable under persuasion than under strict discipline. For several months he has been getting along very well indeed and is now making excellent progress. He no longer has any tendencies toward truancy or delinquency and there is no difficulty in respect to discipline.

ENVIRONMENT AND DELINQUENCY.

We encounter cases of delinquency and truancy which are ascribed to familiar causes such as faulty environment, bad com-

panions, improper home training and other similar factors. Let us attempt to understand some of these influences in terms of how they affect the developing minds of children. Such influences, are, of course, present throughout very early life—poverty stricken homes in which the father and mother both go out to work and do not return until night. One knows what often becomes of the children during this time; the older ones are in school during the school hours, and in the streets until six o'clock when the parents come home. The younger ones are left with another family in the neighborhood, to whom a small sum is paid, and they are brought home at night to have their supper and go to bed. What is the effect of this unusual situation upon the minds of small children? We sometimes hear of overcare and solicitude of parents for children, but is this not an example of the other side of the question? These small children experience to a very slight degree the usual relationships existing between parents and children. They know very little of kindness or solicitudes for ordinary needs, and the question of systematic instruction or training does not enter their lives at all. It is generally recognized that proper training in family life is proper training for citizenship, and if these children learn nothing of respect for authority or of obedience in early years, they are not very likely to acquire it as they grow up.

Then another element enters into the situation. In the instances where both parents must go out to work to support the family, or when for any reason unusual hardships exist, the children at the earliest age possible are obliged to look out for themselves in respect not only to their special wishes, but also for many of their actual physical needs. Such children must, by hook or crook, obtain for themselves everything except perhaps the bare necessities of life. There is a constant sense of responsibility and they can turn to no one for continued assistance. The child then enters the field of competition to obtain his needs and this opens up a situation which brings him into contact with minds more mature than his own. He cannot compete in childish ways and he must attempt to learn the ways of an adult. He must win in any case, so he learns, little by little, to deceive, to falsify emotions, to disguise or misrepresent his feelings—in short, he acquires all these ways of deception with which one is so familiar. This all comes

about at an early age, so that with small children of 10 years of age one encounters all these unfortunate traits. These dishonest tendencies develop because the immature mind of the child is handicapped and is not a match for that of an adult when brought into competition.

These conditions, then, are the outgrowth of artificial social situations, and if the child continues in this way from the ages of 8 to 14, let us say, the development is indeed unfortunate. An anti-social attitude toward the rest of mankind has been formulated, the child has been placed on the defensive, and has fought with the weapons he has developed. Slyness, deceit, falsehood—these are, too often, some of the products. The child, for reasons quite without himself, has become anti-social. After these boys reach the age of puberty it seems quite difficult to modify their attitude for a number of reasons. They are about to be released from school, they are independent, they are earning a livelihood, and have found their pleasures in their own particular way, feeling no need of change. They have reached the adult level and the problem has assumed a different aspect. But before they reach early adult life it is quite different. If environmental conditions can be improved, and proper influences can steadily be brought to bear at that time, there is every reason to believe that these boys can be reclaimed. A child, after all, can be influenced for good as well as for bad, and we certainly have examples of what can be accomplished. Probably a fair proportion of these boys turn in the right direction in any case as they mature, but it is much more logical to give them assistance at the proper time.

A case in point is that of a boy now 11 years of age, who came from the truant school about six months ago. The history of his case is a fairly common one. His father would not keep at steady work, spent all his money gambling, and did not support his family. The mother was constantly nagging the husband—doubtless with good cause, and was unable to cope with the situation and manage the children. They became dependent upon charity and were assisted from time to time. As the oldest boy grew up he followed in the footsteps of his father. He married, spent his money gambling and deserted his family. The younger children, of whom our patient is one, would not obey the mother, and the home was in a very bad condition. Added to

poor management there certainly was a great deal of actual want on many occasions.

The boy grew up in this way, began to show delinquent tendencies early in life by stealing things about the house. He used to be out until one o'clock at night. He would not obey his mother, quarreled with the other children, was responsible to no one. His father used to beat him on occasions, but, of course, gave him no upbringing at all worthy of the name. He finally took up with bad companions, he became a truant, his other delinquencies increased and it became necessary to send him to a truant school. This boy appears, then, to have had a bad start in life—an irresponsible father and an older brother of the same type. He was neglected in early life and developed tendencies of thieving, disobedience, and truancy. One might have expected him to turn out like the other male members of the family, but fortunately other influences were brought to bear.

With a complete change of environment and of general conditions the boy soon began to show improvement. He was away from his old companions, he took up life anew and he ended up by obtaining an excellent record at the truant school. When he left, the principal of the school gave the following report of him: "This boy was promoted twice at this school, and when he was paroled he was in 5-A grade. His record in school and deportment was of the best. He never gave us any trouble, and he took a great deal of interest in his school work." He has now been on probation for five months, making a period of good conduct for a year, and he has been a model boy. He has excellent intelligence, his conduct is good and there are no complaints of him in any way. Fortunately some changes have occurred in the home which do away with the former unfavorable influences, and the boy seems to understand the entire situation very well.

CONCLUSIONS AND RECOMMENDATIONS.

What recommendations are to be made to meet these delinquency and behavior disorders in children?

We have seen that with one group of cases truancy and delinquency occur in the nervous child, due for the most part to inability of the child, because of his nervous condition, to adjust to the rather rigid requirements of school life. Again we have seen

that certain personalities while often possessing exceptionally good qualities, still are so constituted as to be unable, unaided, to make suitable adjustment in the environment in which most children must get along. Then there are the cases which are the product of the environment itself—these cases gradually developing because of the combination of circumstances—these probably being the most unfortunate of all because of the continued unfavorable development in adult life.

The first step would appear to be an examination of the child both as to his physical health, and as to the social and environmental conditions bearing upon the problem. At times the difficulty may be dependent upon some physical disorder such as defective vision, or adenoids, or malnutrition, and in such cases the remedy is comparatively simple. But in the majority of instances the social and environmental problem is the important one. The medical examination should be supplemented by a social investigation, and to carry out this work social service workers with a knowledge of psychiatric problems are of great value; and for carrying out certain recommendations, an association with Child Welfare Societies is necessary.

A necessary feature of the management of these children is their separation from the general classes of the school. Whether this should be done by arranging for a special class in the general school, or whether a separate school should be made use of, is a question which would have to be considered from all angles. But in any case, separate classes are quite necessary. These children do not get along well in the large classes and they are a disturbing element for the others. They need special observation and study, and arrangements have to be made for recreation or teaching which cannot be carried out in a general class. Whenever possible it is desirable that they receive the same kind of general education as the other children, as they are handicapped without it, and their individual tendencies are accentuated if their education does not conform, in a general way, to that which others receive.

In many instances it is probable that transferring the child to a separate class and making such arrangements for him as may be indicated, would solve the problem. But in many of the cases also, a change in respect to home and neighborhood environment

is necessary to meet the situation. In such instances when taking up the question with the parents it might be shown that it was desirable for the child to have a complete change of environment by living in another home for a time and getting away from old associates. In still other instances, where some specific treatment is needed, the child might be placed in the country for supervision by special welfare organizations, and with most cases, diversion and recreation of the proper sort should be made available. As stated above social service workers with psychiatric training are valuable to do the necessary investigating and the follow-up work. A feature of this service which would seem particularly advisable is a follow-up system after the child leaves school. Such children need guidance, of course, quite as much at that time as at any other, and it is quite evident how much could be gained by this feature.

What results may be expected from therapeutic agencies as outlined above? We are scarcely in a position to know the extent of the benefits which may be had, but we do know that comparatively little can be done in the management of such problems unless they are understood. In approaching questions of this kind, a knowledge of the medical and social background of the cases is needed, in the schools, by the public and by the medical profession as well. In this direction, of course, has been one of the greatest needs of medical education in the past. In matters pertaining to the health of the body much attention has been given; but in matters pertaining to the social and environmental influences which may make for mental health or illness, much less has been accomplished. With a broader dissension of the understanding of these problems there is reason to believe that important advances may be made. If we are right in thinking that these conditions are, after all, much more susceptible to treatment and management than perhaps was thought at one time, the gains for both the individual and for society would be very great.

Of course it is almost needless to say that the proper time to effect these changes is during childhood. It would be unfortunate for any one to get the impression that such conditions as delinquency and conduct disorders of school children are not susceptible to change. In adults we meet with them after they have been developing for years, and then, indeed, they may be very

firmly fixed. But during school age is the proper time, not only to inculcate proper ideals and ambitions, but also to correct tendencies which may be detrimental to character in later life. In observing these cases of delinquency one gets the impression that the very terms used, such as incorrigibility, chronic truancy, and so on, make the situation appear much more formidable than it really is. These children are apt to be regarded as being inherently abnormal or different from others, but if they can be given the proper assistance before their tendencies become rigid and fixed, it is believed that the remedy is not difficult.

Delinquencies in most instances are not serious affairs in the beginning. They often start as the result of mismanagement and an intelligent handling of the situation is all that is necessary to correct early cases. We surely cannot associate these minor cases with the conditions we encounter in adult delinquents; but one is nevertheless inclined to believe that these same minor cases, if allowed to go on year after year in school life, gradually become more marked, and may, indeed, turn out unfavorably later. It is felt that we must free ourselves of the idea that these conditions are inherent or inherited, and so there is nothing to be done about them. They are to a great extent the result of failure on our part to do the best possible thing for a very important element in the community. This failure has been due to lack of understanding rather than to conscious indifference or neglect, and it is felt that the support of the people in any community may be depended upon, when recommendations are made to them as to how best their children may be assisted and guided.

GROUP MENTAL HYGIENE.

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In a paper read before the New York State Conference of Charities and Correction in November, 1919, entitled "New Fields for Mental Hygiene" I attempted to summarize public and professional knowledge and treatment of mental disorders from a developmental point of view, and to outline the more recent mental hygiene movement, its origin and present scope of operation. It would be superfluous to recount any of these steps before such an audience of specialists as the American Medico-Psychological Association annually convenes. With your permission, to avoid confusion with my previous paper, I am changing the title that appears on the program to "Group Mental Hygiene" as this more specifically describes the field of our present inquiry. Mental hygiene may be briefly defined as the science of the promotion and preservation of mental health. Organized work in mental hygiene has been chiefly occupied so far in procuring better housing, more institutions, better treatment within institutions, in statistics, and in bringing to bear the newest and best ideas of treatment for both intra- and extra-institutional cases of insanity and mental deficiency, but very little has been done along preventive lines and still less in group mental hygiene. In other words mental hygiene up to date has been almost entirely an individual mental hygiene. The psychiatric eye has been focused on the unit but not the whole; we have been deeply concerned with the link, but not the chain. I do not mean to minimize the study of the individual, for of course this is fundamental but I do hope to demonstrate or at least to suggest that group mental hygiene is of great importance and from now on must occupy a very large share, if not the largest in any mental hygiene program.

What do we mean by group mental hygiene and what does it include? Group mental hygiene embraces all the sociological

factors that enter into the general subject of environment. We might begin with the modern family as a unit—but its influences have been so outweighed by stronger ones of which we shall speak, that we shall omit, in this present discussion, consideration of the family as such and its early history and development. We shall define a group (and we shall use the word as synonymous with “crowd” and “mass”) as a collection of individuals. A group may be large or small, and may be specifically a more organized body of men, such as a trades-union, a religious denomination or a fraternal organization, or may be a larger group and less organized, such as a village, a city, a state or a nation. Whatever size the group possesses, it is always composed of individuals and yields a composite and a resultant of individual mentalities, and individual psychologies, each of which are influenced by the interrelationships and effects of living in the group. Certain inherent individual traits pass over into group traits. These traits, most generally agreed upon by crowd-psychologists, are *imitation* (general reproduction of action), *sympathy* (general reproduction of emotion) and *suggestion*. We shall not have the opportunity to analyze or discuss the interesting psychological points involved. You will readily admit, however, that whatever names describe them, they have most important bearings. I shall only mention a few of the numerous instances which may be used to illustrate their working. Here are some of them without any attempt at classification or further analysis; fads, fashions of dress, slang and fashions of speech, imitations in manners of housing, of living, of recreation, and many others may be named. Suggestibility is a most prominent group characteristic. You need no illustration of this for you well know how easily crowds are swayed this way and that. Advertising, for instance, is built around this particular trait. The history of slogans and their use is an example in point. You remember “Millions for Defense, but Not One Cent for Tribute”; “Rum, Romanism and Rebellion”; “Thou Shalt Not Crucify Labor upon a Cross of Gold”; “Remember the Maine”; “He Kept Us Out of War”? Many other slogans may be mentioned (which have played important rôles in history) to further illustrate group suggestibility. The latter also embraces impressibility and changeability. Changeability is a prominent crowd trait. An example of this is group

opinion concerning public officials. Dickens comments on this in his "American Notes" written in 1842 in which he deprecates the "universal distrust" by which popular favorites are as easily cast down as elevated.

But these group characteristics are by no means always factors for ill. They may be equally potent elements for good in the Social Evolution. The important task for group mental hygiene is to control and guide them in ways beneficial to the group.

The external conditions of civilized life have been so changed by rapid transit, telephone, telegraph and printed language in the last one hundred years that groups, cities, states and nations have been brought together into a much closer social organization, until the whole civilized world in reality forms a group, and no important social-economic change, crisis, panic, famine or mental attitude can happen, even at a remote distance without affecting some or all members of the group. We have reached on this account a stage in which group influences have become so intensified that the situation to-day calls loudly for their frank recognition and regulation.

In addition to the psychological elements that are operative individually and collectively in a group, we may consider group mentality as a whole, which may be subdivided into the familiar volitional, intellectual and emotional spheres. For some time we have seen in the literature such terms as "national psychology," "mass psychology" the "collective mind," and "collective affect." Hinrichsen in his "War Psychoses of the Belligerent Nations," gives as examples of collective affect the "revanche" idea in France, and "Italia Irredenta" in Italy. Numerous other instances might be added. We are now in the midst of a number of prominent group affects, in Ireland, in England and on the continent, which have arisen during and since the great war, but which are so contemporaneous as to be difficult of analysis. Hinrichsen speaks also of a "national psychosis" which he states is manifest in newspaper headlines. Grodich in 1848 described a "Morbus Democraticus" which he believed to be more disastrous in its influence than the psychosis of war as it leads to national disintegration, impotent individualism and finally to a psychosis of revolution.

We are dealing of course with a deep-seated, many-sided problem, and some may ask what has psychiatry to do with all this? I will endeavor to show by a few concrete instances how psychiatry is necessarily involved. In mental hygiene of the group the psychiatrist must be a prominent worker, although psychologists, sociologists, economists and others have important fields of activity.

Let us turn from generalities and take up some concrete instances of group influences and their effect. There is hardly a better example than a study of the effects on mankind of urban life. First a few statistics on the movement of population from the country to the city. In 1790 only 130,000 of 4,000,000 then populating the United States, lived in towns, or about 4 per cent; in 1910 the total population had increased twenty-five fold and urban population relatively had increased over four hundred fold. I am confident the new census will show still more startling and disquieting figures. The number of cities of over 100,000 population increased from 20 in 1880 to 50 in 1910 and the aggregate population in such cities from 6,000,000 to 20,000,000 or over 200 per cent. The proportion of the total population living in cities of this class increased from 12 per cent in 1880 to 22 per cent in 1910. In New York during 1900-10 population increased 25 per cent while the number of farms decreased 5 per cent and farm acreage decreased 2.7 per cent, and improved land acreage 4.8 per cent. It is stated that the abandonment of farm life during the past year has left vacant more than 24,000 habitable farm-houses in New York State, while people are camping in tents or indulging in a wild scramble to find living quarters in terribly overcrowded cities. I am informed that in 1920 there are 50,000 less laborers on the farms in Iowa than in 1919, and as near as I can make out the situation is just as bad elsewhere. As I was writing this I happened to pick up a recent number of the *Literary Digest* in which the leading article was entitled "A Grave Food Shortage Predicted." May I quote two brief instances from this: "A Missouri farmer went to Kansas City the other day to get two men. In front of a movie at the afternoon performance were probably forty husky youths waiting for the doors to open; not one of them would work on a farm. In Indiana swarms of idle laborers are besieging the factories, but refuse to work for less than \$1.00

an hour, while the distressed farmers vainly offer hundreds of good jobs with good wages and board. These men many of them with farm training, want to work only a few days a week at high wages." I dislike to be a prophet of ill, but I firmly believe we are fast approaching an economic crisis due to the overbalancing of urban population and the resulting diminution in the production of the necessities of life.

"Ill fares the Land, to hastening ills a prey,
Where wealth accumulates and men decay.
Princes and Lords may flourish or may fade,
A breath can make them as a breath has made,
But a bold peasantry their country's pride,
When once destroyed, can never be supplied."

Goldsmith wrote this in 1770, but it could not be improved upon for 1920 conditions.

Let us inquire into the effect of urban life as judged by the cases of recorded mental diseases. Table 50 of the last U. S. Bureau of Census Report shows that of the insane admitted to hospitals in 1910 the ratio per 100,000 for cities of 500,000 and over was 102.8; the ratio gradually declines with one exception to 70 for cities of 2500 to 10,000, while for rural communities it was only 41. Pollock shows that of the 6797 first admissions to the New York state hospitals for the insane 86.9 per cent were urban residents, 12.9 rural. The 1912 reports from the same hospitals give the greatest ratio of insanity in the largest cities, while the rural districts are the lowest. Of the 5742 first admissions in 1912 to the New York institutions, New York City alone contributed 58.3 per cent of the total. Pollock also gives us in a recent number of N. Y. State Hospital Quarterly figures on the geographical distribution of dementia præcox which give further supporting evidence. In first class cities (New York, Buffalo, and Rochester) the ratio of dementia præcox was 114 per 100,000; in second class cities 90.9, in third class 65.1, in villages over 2500, 54.3, and in rural districts 40.4.

These statistics and other facts such as the greater prevalence of alcoholic psychoses, paresis, and drug addictions in cities clearly indicate that there is something wrong with modern city life—that group influences are intensified beyond the safety point. It must be seriously considered if the main artificial environment

developed by *homo sapiens* for himself—urban dwelling, especially in enormous groups, is not a destructive agency that should be modified by every possible human means. My positive opinion is that the facts regarding urban dwelling should be freely circulated and the situation remedied. In this work mental hygiene should have a prominent part.

Inter-group relationships form a most important subject for group mental hygiene. The division of labor or specialization of work tends to isolate groups and create inter-group struggles for supremacy. Trade-unions have been an outgrowth of this division of labor. It is apparent that much of the action of these unions is taken without consideration or realization of the interdependence and relationship of all groups. Capital in many instances may be similarly indicted. The years 1919-20 have witnessed numerous examples of this in the ruthless and shameless profiteering in sugar, milk, coal, shoes, clothing and other essentials of life—manipulations carried out without regard for the effect upon the health and happiness of the group as a whole. I would like to take up what seems to be a serious defect in the organizations of trade-unions. There appears to be no recognition of individual and native differences. A standard days production is scaled down to the average ability. There are men who could work more rapidly than this, but they would get no greater remuneration if they did. I noticed the other day a new scale of wages for railroad men—in this the switchmen, yardmen, brakemen, and no doubt others I cannot recall were given the same or practically the same wages as the locomotive engineer, a much more technical job that requires more training, years of service and sustained responsibility. The attempt to level and equalize in a uniform wage and uniform output is bad on account of its two main results, a lessened output and a check on individual stimulus and ambition, for why aspire to any position that requires education and years of training when the same or even better returns financially may be obtained in positions requiring less skill? All this is contributing to the economic unrest of to-day. But in spite of the conscious effort to level and equalize, individual differences are ever present.

You are familiar with the group intelligence tests made in the army cantonments during 1917-18, in my opinion the most impor-

tant sociological event of the whole war period. Nothing could more clearly show the vast intellectual differences that exist within the group—the leaders, the officers, the professional men and the technically trained were at the top of the scale, unskilled labor at the bottom. The same individual differences within the group exist the world over. Of course there are lessened ranges within selected groups; but nowhere is there uniformity. We are far removed from the average man. This is the reason, of course, that communism, so fondly favored in other times as well as now, is impossible.

The average mental age as found in the army psychological statistics was a little more than 13 years. This fact has deep sociological significance. With this in mind, we can better understand perhaps the action of the group and the motivating imitation, sympathy and suggestion, and the need as well for intelligent guidance and leadership.

Group psychometry is destined to become an important feature in mental hygiene work. Studies of larger groups which show distribution of intelligence within the group, and also permit comparisons of one group with another, are now possible. In the long run such statistics will show if groups, cities and states are advancing, at a standstill, or are deteriorating.

Finally, may I briefly refer to a few of what seem to be the present-day ills of the group and close with some suggestions for counteracting them.

The automobile is very much to blame for present economic difficulties. The industry has grown to such enormous proportions that a decided economic unbalance has been produced largely due to the attraction of labor from essential occupations such as farming. Useful as the automobile is, yet there is much in its popularity that may be classed as a fad and a craze not without decidedly harmful effects upon the group.

In addition to the speed and motion craze in which the automobile is an important participant there are other character defects of the group. Too many lack objectives or goals, they seem to be floating along without ideals, or perhaps it is a question of proper ideals. This seems to be an age of slipshod work in which we often hear the phrase "get by," which appears to be the sole ambition of many, with the means often unquestioned.

How shall we improve our present state? There are five main avenues of approach: (1) Education; (2) organized religion; (3) mental hygiene organizations; (4) the press; and (5) the medical profession. I shall not take these up in particular, but in general we need these things: Life should be simplified, slowed down; the simple principles of honesty, honor, and unselfishness need to be emphasized as never before, mutual relationships and interdependence should be more appreciated and kept in mind; and charity, kindness and justice should prevail in more of our human relationships. We need constantly to reaffirm the old truths such as "honesty is the best policy," "do unto others as we would ourselves be done by," "contentment is better than riches," "health is wealth," and show why these old sayings are ever true. We need also to affirm the joy of work well done, be it ever so humble. We need to spread broadcast the facts of individual differences. While we should never fail to provide equal opportunity for all, we should not remain blind to the fact that all are not equally endowed to benefit by equal opportunities. We need very much to dignify the small job; we are already realizing how essential the small job is to the group. The society of the future will find out the abilities of the individual and suit the man to the job, better than we are doing now.

The schools will have an important share of this work, in classifying their material at an early age according to ability, training for leadership, for trades and many other phases of life's work, but especially for citizenship.

AN EXTENSION COURSE IN PSYCHIATRIC SOCIAL WORK.

By HAROLD I. GOSLINE, M. D.,

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The idea had been taking root in Rhode Island for some time that a course of instruction should be given to meet the needs of the workers in this state, to give them some insight into the psychiatric view-point. Miss E. Frances O'Neill of the Providence Society for Organizing Charities had seen the desirability of having her workers acquire this view-point and had been instrumental in spreading the theory among other groups of workers in and out of the city. But the problem of Providence is rather unique in a way, as I may suppose can be said of the problem of each community. Communities, I take it, are like individuals, different, and the problem of Providence is perhaps not the problem of any other American city and certainly not like that of any European city. However that may be, it was thought desirable to try the experiment of getting something of the psychiatric view-point and the experiment has been tried with the result that it now seems desirable to publish it with its results, both the desirable and the undesirable.

Dr. Arthur H. Harrington, the Superintendent of the State Hospital for Mental Diseases, was especially interested in the projected experiment and he and Dr. G. Alder Blumer, the Superintendent, and Dr. Arthur H. Ruggles of the staff of Butler Hospital, opened their wards for the demonstration of illustrative cases, and aided the work both directly and indirectly in numerous other ways. The experiment was watched with lively interest by the State Penal and Charitable Commission and the Trustees of Butler Hospital, both composed of men of proved public spirit and humanitarian interests.

The cooperation of Brown University was sought and every facility of the University was put at our disposal to insure the success of the experiment. The type of material at hand, the fact that those who would most probably be interested were already

engaged in some form of social or community work or were teachers in the special schools of Providence, together with other decisive considerations, led us to adopt the plan of presenting the material at hand in the form of one of the Extension Courses which have been given at Brown University on matters of public and general interest, for several years.

The choice of a title for the course seemed a matter of considerable importance. Should we call this a course in Social Psychiatry or in Psychiatric Social Work? The question may seem to be one of academic interest merely. I would like to digress for a moment to defend the thesis that the choice of a title for such a course or for any course dealing with such kindred matters, is a point that should demand some thought and no little attention. If we are to talk about social psychiatry, is it not reasonable to predicate a certain amount of knowledge about social psychology? And what are we to accept as standard in the matter of social psychology? When we speak of the mind of the nation or of the mob or of the family are we to imply a mystical higher personality which exists somewhere above the individuals? I think you will be ready to reply in the negative and yet that is just what many persons who are talking about these matters do imply because they have not considered carefully enough the implications of just this seemingly academic question, which enters into our choice of a title for this course. Social psychology begins where two or more persons enter into actual relations. The individual experiences mental states which would not enter his consciousness without the existence of other men. The simplest gesture or imitation as well as the most complex act controlled by custom or fashion or by law involves the consciousness of the social group. The social psychologist deals with the mental functions as the real objects and does not start with the group; the social psychologist must always begin with individuals. The processes of language, of customs, of faiths, the life of primitive peoples or of highly civilized communities may properly be the object of his study as well as the intellectual or artistic or religious or political or industrial leader. But in the case of these leaders it is the mutual influence between the leader and his followers or his opponents which comes within the province of social psychology.

If men were mentally alike, the social groups would have an entirely different character. The elements of social psychology, therefore, are individual differences but only those differences which have significance for the social organization and the resulting social mental states need be considered. These differences may be classed under those due to age, those due to differences between groups of individuals, the differences in character, temperament and intelligence between individuals, and the differences due to abnormal variations. The next step in the development of the social mind is organization. Organization depends upon the getting together of the elements in the social group and all processes which work toward this end may be classed under the general heading, union.

Union is made possible through communication of a voluntary and of an involuntary sort, and this communication is brought about by language and by association into groups which range from the chance meeting of two persons to the bonds of matrimony or from a chance group in the street to an industrial community with its cumulation and division of labor. Yet the manifoldness of social groups would be impossible on the basis of mere coordination of individuals. Two other processes are present, known as submission and self-assertion. The former takes place through suggestion, imitation and sympathy; the latter through aggression, self-expression and self-display. These are the simple social processes.

The complex social processes may be summarized in the expressions, organization and achievement. Organization shows itself in the literature and institutions of the world and is itself moulded by them. Such organization may be voluntary or involuntary, temporary or lasting, immediate or indirect, personal or institutional. Achievement is a sign of biological usefulness and the death of social groups is due to ill-adjusted achievement, a lack of adaptation to the conditions under which they are organized. The material for this sort of study lies in moral statistics, industrial statistics, political statistics. The laws and the literature, the churches and the cities, tell the story of the working of the social groups. Assimilation is necessary for achievement; assimilation of the laws, the customs, the language, the history, the traditions and the beliefs of the group concerned. New social influences and

productions, leaders, *et cetera*, bring about a ceaseless forming of new organizations which makes up the progress of civilization.

Now the course given at Brown did not deal with group psychology or psychopathology. It did not consider destructive habits such as race suicide or over-indulgence in alcohol. It did not talk of revolution or massacre, graft or corruption, lack of public spirit or recklessness. It did not discuss foreign enemies or imported social poisons, customs and beliefs. It had nothing to do with individual differences, or with union, communication, submission and self-assertion, or with organization, literature and institutions, or with achievement, industrial, moral and political statistics, assimilation, new social influences and leaders.

On the other hand it did deal with individuals from the normal and the pathological sides. Does not my thesis, for the defence of which I have made this long digression, seem to be substantiated? It is substantiated by the fact that the course did not deal with anything pertaining to social psychiatry and on the other hand did deal with many things pertaining to the psychopathology of the individual.

Nor am I content to let this matter of selection of a title for such a course drop with an exposition of the reasons for the selection of the title to stand for the extension course at Brown. I would like to conduct a little raid of my own into the camps of those who are giving courses in social psychiatry, to ask them if they have considered these matters and whether they do not think that the time will come when true social psychiatry may be taught, to the confusion of those who are now being led to believe that they are studying social psychiatry?

Let us turn from this friendly gibing to a consideration of the conditions which obtain in an extension course. In the first place the usual extension course is a matter of ten lectures. Secondly, the lectures must be given in the late afternoon or the evening because the lecture-halls are for the most part occupied during the day by the regular students of the university. Thirdly, an extension course is designed to deal in a popular way with the topics of the day. Such conditions might make one hesitate to even consider an attempt to present psychiatric social work (supposing that is the proper title), as an extension course. In fact the

objections to this method of presentation were numerous from the less sanguine of those who considered it. In the first place, ten lectures were considered an entirely inadequate number in which to hope to put the subject matter across. Only the buoyant hopefulness of youth could see a chance of success.

The fact that only certain times were available happened to be a fortunate matter as these periods in the way prevented us from selecting the wrong periods and happily coincided with the best time for an audience, as an enrolment of fifty-nine later proved. This number proved to be the largest in any extension course given in the university this year. Only thirty-five would have been necessary to insure the financial success of the course, which is a matter that has to be considered from the university's point of view, I imagine. In the third place we could not consider psychiatric social work as a topic of the day, much less could we present it in popular form, so to speak. In spite of this, the regular announcement in the daily papers which is printed before the extension courses are given did bring out one electrical engineer whose hobby for many years had been matters directly or indirectly relating to psychology. For the rest, of course, we attracted those who were interested in the special schools of the city of Providence and in the various forms of social and philanthropic work which are going on in the city, both of which groups showed a wholehearted and untiring interest in the course. Apparently also we interested a still larger field than we had anticipated if we are to judge from the number of visitors to the clinics held in connection with the course, who were not registered in the course itself. Such enthusiasm has led us to hope for greater things in the way of a combination with the other allied courses.

The method of presentation was by lecture supplemented by the clinic. The lectures were illustrated by means of charts which summarized the main elements to be driven home; the charts naturally used the visual route to the minds of the hearers and it is well known that this route must be used in order to make the greatest impression. Of course this absence of visual impressions is the very thing that makes the teaching of psychology most difficult; how to reduce what one has to say to visual images is

the great feat. The first lecture was given to orient the student in the total field. It is a matter of common observation that specialists get to see only their own corner of a problem. This is as true of specialists in social work as it is of specialists in medicine or science, perhaps more true. However that may be, it seemed desirable to give a bird's-eye view of the whole field, using the material which has been produced during the past few years as the basis for the lecture. It almost seemed as though the lecture were a set of plagiarisms from many authors. If it was, it had this advantage, that it presented the material views from many sources and did not savor of individualism too much. The second lecture sought to be an exposition of introspective psychology and again did not necessarily represent the speaker's views but was chosen as the form of psychology for the background of the course because it seemed to offer the possibility of some tangible anatomical correlations. I can not here go into the reasons which have led me to this opinion nor can I go into the analysis of consciousness as we did in that lecture. Suffice it to say that personality was shown to consist of certain complex mental functions called perceptions, ideas, activities and inner states and then it was shown that these complex functions could be reduced to simpler mental processes known as sensations, association, reaction and inhibition. Charts of an anatomical conception of the higher reflex pathways in the brain were devised in accordance with this psychology and the suggestion offered that they might be used though emphasis was laid on the fact that they had not been tried out and that they were merely a logical deduction from introspective psychology.

The next five lectures dealt with psychopathology, using the eighth edition of Kraepelin as the basis but rearranging the order presented in that work to make it conform to the psychology as presented; this made the correlation in the minds of the audience more certain, I am sure. In such a course with such a short time at one's disposal every advantage of this sort must be utilized. No pains should be spared to avoid every chance for confusion. Irrelevant details must be entirely passed over and considerations of a confusing nature must be stringently avoided. Otherwise there will result in the minds of the audience a hopeless confusion which will lead them into a maze of doubt and uncertainty and

finally convince them that the subject is entirely over their heads and in that case, I take it, they are right.

The time was never too short to stop for a concrete illustration and the clinics at Butler Hospital and at the State Hospital for Mental Diseases at Howard served to erase any doubts that might have hung over from the previous lecture. At the clinics no case was presented *in toto*. The clinics were given up entirely to the illustration of symptoms which were to be discussed in the following lecture, that is to concrete examples of the points in psychopathology which were to be considered at the next lecture, and these were so arranged that each lecture could be referred back to the psychology upon which it was based and which had been given in the second lecture. In addition, points that remained unelucidated from the previous lecture were discussed and there was constant repetition of salient points with equally as constant avoidance of any maze, such as that of classification, for example. After the regular lecture, those who were taking the course as students were required to remain for informal discussion, and those who had registered as auditors were invited to listen to the discussion. In this way another repetition took place, this time in an informal way which served as no other method could to show the instructor how far his words had really arrived. The questions were usually few because pitfalls had already been avoided but those asked did much to lead the teacher into the proper paths for further emphasis. He was enabled to take one moot point at a time and attack it from many possible angles, constantly and religiously avoiding statements which could lead to additional complication. It may be questioned whether such a procedure is at all desirable. I would reply that it is not, but that it cannot be avoided if an extension course is to be successful.

This leads me to two other considerations with which I will close, namely what constitutes the success of the course and what should we desire if such a course were to be continued? I should assume that the course had been successful if the psychiatric viewpoint had been instilled into the minds of those who attended. By that I mean that those who took the course will have to regard the insane patient as they would regard a patient suffering from pneumonia for example and when he recovers will go to meet him in the same way that they would meet a recovered pneumonia pa-

tient ; that they are so sure of their own attitude in the matter that they can be depended upon to carry that attitude into all their thought and actions where the insane are concerned. I mean that they will have come to recognize that there is a difference between insanity and mental disease and to be able to detect what the difference is. They will be able to recognize that something is wrong with the mind of those with whom they have to deal and know when to call in the psychiatrist. That is the chief point, not to be able to give a diagnosis, but to be able to tell when a diagnosis should be asked for. I should consider the course a success, thirdly, if my audience acquired an interest in the matter. I think it may be said that the course of ten lectures can be made a success if we use these criteria of success.

What more is to be desired then? The objection may have come to you that students in such a course may get the impression that they have acquired a great deal more than the facts warrant. Such does not prove to be the case and yet I think it may be said that the acquisition of a little more knowledge could not be considered undesirable. In other words, the foundation for an understanding seems to have been laid and we should hope, expect and reasonably desire that a more complete course might be given as a complement to the present one. The foundation has been laid in a psychology which is tangible, the psychopathology has been deeply impressed by the consideration of symptoms alone and these have been illustrated by actual cases. The next step should be to demonstrate the multitudinous combinations into which these symptoms may enter and from this step to teach how our conceptions of disease entity are constructed.

However, it occurs to me that social workers, teachers in public schools for backward children, and district nurses should not be expected to know too much about frank insanity, not because such knowledge can ever be thought inadvisable but because they do not often see cases of the frank psychoses. On the other hand they often see abnormal mental traits which lead the people they are dealing with into all sorts of social and moral difficulties, or make them misfits economically and industrially. They should recognize these finer traits of which they see only the gross caricatures in the hospitals for the insane. Thus, while many social workers will bring an extended knowledge of sociology with them

to the course, the knowledge of sociology which they may be expected to get in connection with the course is desired only with the object of teaching how far the finer mental disorders are at the bottom of sociological difficulties and problems. In such a course they cannot be expected to get the group idea. That should be left to a still later stage in their development if, perchance, they have not already acquired it, and in that stage they should also get another aspect of psychology, namely, the behavioristic. But to give behaviorism in the second course when one is trying to refer everything to introspective psychology would be fatal; it would lead to confusion and doubt with the results mentioned above to be expected.

Another factor is desirable also in this extended course both for the training that it gives in exact thinking and for the reason that we are dealing with a psychology that is tangible and that may reasonably hope to correlate with anatomy, that is neurology. Such a course in neurology should not be a general one but should be related to the course in psychiatry in the most intimate way, very much in the manner that the course in sociology may be expected to be related. This intimate relation of all three subjects precludes the possibility of their being given as separate courses. The program of subjects should be arranged beforehand and the neurological and sociological topics should be introduced at the psychological moments, so to speak. Such a course, which is the sort of thing now being contemplated, will necessarily take more than ten lectures. More credit in the matter of points will be expected and given. The interest is already ours. How can the outcome be anything else than successful?

NOTES.

The section of this paper dealing with Social Psychology is abstracted from "Psychology, General and Applied," by Hugo Münsterberg, D. Appleton and Co., New York, 1914, pp. 224-285.

The charts which were demonstrated in connection with the paper are to be published in connection with another piece of work. Hence they do not appear here.

DISCUSSION OF PAPERS BY DRS. CORNELL AND GOSLINE.

DR. E. STANLEY ABBOT.—I was very much interested in Dr. Gosline's outline because I have been trying this last winter to give a course in "social psychiatry," as it is listed in our catalogue. There is a school

for social service workers in Philadelphia that gives a full year's course. I had the advantage of having the subject of psychology taught during the first half-year in 14 or 15 lectures, by Miss Jessie Taft. I gave the course myself in the pathological part. My approach to it was from the biological point of view. There was first an introductory talk on behavior as determined by psychological, environmental, hereditary, and constitutional factors, make-up, and factors due to bodily and mental illness, and the possibilities of relief and prevention of morbid behavior. This was followed in the successive lectures by the consideration of behavior as affected by alcohol and drugs, by organic brain lesions, by that peculiar make-up which we call psychopathic personality, and by the different types of psychoses, psychoneuroses and epilepsy.

The course was well attended and the pupils seemed interested.

Since I had had nothing to guide me as to how to make up my course, it was interesting to hear Dr. Gosline's method of attacking a similar problem. We are trying to do the same sort of thing—teach a certain amount of psychiatry to social workers so that they will get the psychiatric point of view and understand it.

DR. BLUMER.—I want to say a word of thanks to Dr. Cornell. I listened with great interest, and was pleased with what he had to say about the automobile. He showed a great deal of courage in placing his finger on the greatest plague-spot of modern life right here where so many automobiles are manufactured. He quoted very effectively what Oliver Goldsmith said. How can one expect that young men will stay on the farm if they have a Ford automobile to get into town to see the movies? I suppose Rhode Island is no different, in the matter of motoring, from any other state. I have often noted the expressions on the faces of those people who are supposed to be "joy riding"; there doesn't appear to be the slightest trace of joy about it at all; they are simply gadding about from place to place in futile locomotion.

Dr. Cornell quoted Oliver Goldsmith, and I fain would quote to the same effect something that John Ruskin said many years ago, with reference, not to the automobile, or to the telephone, which is only second as a modern nuisance to the automobile, but to the railway and the electric telegraph. In *Fors Clavigera* Ruskin says this: "To talk at a distance, when you have nothing to say, though you were ever so near; to go fast from this place to that, with nothing to do either at one or the other: these are powers certainly. Much more, power of increased Production, if you indeed had got it, would be something to boast of. But are you so entirely sure that you *have* got it—that the mortal disease of plenty, and afflictive affluence of good things, are all you have to dread?"

DR. JAMES K. HALL.—The last two or three papers are the kind of papers which I imagine Lord Bacon would have enjoyed. They will afford me mental nourishment for a long time to come.

I have been thinking, since Dr. Blumer's quotation from Ruskin, of another quotation in which Lord Bacon is reported to have said: "The

man who prefers solitude is either a god or a beast." People do not have time any more; mankind has little time now-a-days to deliberate on its own opinions or the opinions of others. In connection with this work of educating the public that the National Committee for Mental Hygiene is doing, I am inclined to think that the instruction might very well not be confined to those people we think of as ignorant people, but some of the more highly cultivated. For example, we are apt to delude ourselves into the belief that we are living in a democracy; we are living largely under judiciary government. We had an illustration of that in yesterday's paper. We do not know what the law is until the Supreme Court tells us what it is. We do not know what laws we can make until the Supreme Court tells us. These abnormal children we have been hearing about, whether old or young, are coming in contact sooner or later with the judicial officials and it is these officials that stand most in need of instruction. A great many judges and prosecuting attorneys are terribly ignorant about mental abnormality; they do not believe in abnormalities that carry with them irresponsibility.

THE ABSORPTION OF PHENOLSULPHONEPHTHALEIN FROM THE SUBARACHNOID SPACE IN DEMENTIA PRÆCOX AND PARESIS.*

By PAUL G. WESTON, M. D., WARREN, PA.

Incidental to the routine examination of the spinal fluid in a number of cases of catatonic dementia præcox and paresis, observations were made on the rate of absorption of phenolsulphonophthalein. A neutral solution of the dye having a specific gravity of 1.0061 was used. After the withdrawal of 3 c. c. of spinal fluid for the routine Wassermann, globulin and colloidal gold tests, 15 more cubic centimeters were collected in a glass syringe barrel. One cubic centimeter of the neutral dye was then slowly injected into the subarachnoid space and the needle washed by reinjecting the 15 c. c. of fluid previously removed. This insured some diffusion of the dye and prevented the escape of any along the needle tract when the needle was withdrawn. Immediately after the injection the patient was placed on his back, a catheter inserted and the urine collected in a test tube containing a few drops of 10 per cent sodium hydrate solution. The time of appearance of the dye in the urine was determined and the catheter withdrawn. Three or more days later, the patients were catheterized and when the bladder was empty, 1 c. c. of the dye was injected deep into the deltoid muscle and the time of appearance in the urine determined.

Twenty-eight cases of catatonic dementia præcox and 17 cases of paresis were observed. The appearance time of the dye after intraspinal injection varied in the præcox cases from 25 to 104 minutes and in the cases of paresis from 12 to 68 minutes. After intramuscular injection the appearance time varied from 4 to 20 minutes.

The age of the patient, duration of the disease and physical and mental states had no determinable effect on the appearance time. The spinal fluid from all the cases of paresis showed a positive Wassermann reaction, increased globulin and a paretic gold curve. These reactions were all negative in the cases of præcox. The P_h value of the fluids was 7.4 in all cases.

THE STRUCTURAL BRAIN LESIONS OF DEMENTIA PRÆCOX.

By ADELINE E. GURD, M.D., ANN ARBOR, MICH.

It seems almost a work of supererogation to-day to present a study of the organic basis of dementia præcox, since from the infancy of histological neuro-pathology all skilled observers have been united in recognizing certain essential changes in the central nervous system in cases of dementia præcox. Beginning with Alzheimer's statement in 1897¹ that he found severe changes in the ganglion cells with tendency to disorganization, sparing mitoses in the glia, pathological formation of glia fibres with encircling of nerve cells by these fibres, much swelling of the nuclei of the nerve cells, marked folding of the nuclear membrane, severe shrinking of the bodies of the ganglion cells. Then passing in review all the great names in neuropathology each in turn has contributed a histo-pathological picture of dementia præcox, differing only in the stress laid upon one or other element in the findings but in no case reporting contradictory results. A complete bibliography of the histo-pathological studies of dementia præcox would far exceed the limits of this paper but a few names stand out particularly. Of the earlier observers Cramer² closely following Alzheimer in 1897 reports a case in which "not a single nerve cell shows normal Nissl's granula." Dunton in 1902,³ Laignel-Lavastine⁴ in 1904 and 1905, Klippel and Lhermitte⁵ in 1905, Mondio⁶ in 1905, confirmed the findings of Alzheimer and Cramer. Lhermitte adding a certain precision to the study by dividing the lesions found into fundamental (progressive atrophy of the nerve cells with disappearance of the dendrites which assure the connections of the neurons with one another, etc.) and accidental lesions caused by the direct cause of death or by intervening disease.

Scioli⁷ in 1909 reports 20 cases of dementia præcox in which he found a loss of nervous elements in all parts of the brain, general

degeneration of the nerve cells with increase in fat, the degeneration leading to a slight thinning of the cell layers at times; (b) zones around vessels free from nuclei but filled with degenerated masses; (c) degeneration products in the adventitial lymph spaces and in the nervous tissue, no inflammatory exudate. Nerve fibres often intact where the cells show severe injury. Glia proliferation in the molecular layer, sixth layer and medullary areas and around vessels, sometimes amœboid cells.

From 1909 on the number of observations have increased with the years. Notable amongst them are the reports of Southard⁷ well known to all here, then Cotton's⁸ special work on the fatty deposits in dementia præcox. Orton's⁹ article in 1913, Nissl¹⁰ in 1914, Wada¹¹ in 1910, Moriyasu¹² in 1909, Zimmerman in 1915¹³ and recently a very comprehensive and detailed study of a large number of cases by Rawlings.¹⁴

In the meantime Alzheimer¹⁵ up to the beginning of the war followed one investigation by another until his last published article on this subject in 1913, resuming in his masterly manner the work of the years. He presented his work on 55 cases, 18 of which were uncomplicated by any other disease and he concludes "severe grade sclerosis of ganglion cells with fatty degeneration signifies severe injury to function," thus fixing definitely his position on the subject.

Of interest is Bleuler's¹⁶ expression in 1915 of his belief in the organic basis of dementia præcox. He says: "Many think they are turning against me when they say physical changes lie at the bottom of the group (dementia præcox). I myself have expressly emphasized this fact. One must acknowledge that at least the great majority of clinical pictures which are now collected under the name of dementia præcox rests on some toxic action or anatomical process which arises independently of psychic influences," "that such groups (those arising from psychic causes) exist is yet to be proved, while the principal group in my opinion is certainly caused by organic changes."

Nineteen cases of dementia præcox of unquestionable diagnosis were studied by me by all modern methods.

With the exception of one case, which will receive special attention later, they were cases of dementia præcox uncomplicated

by other diseases, which might influence the microscopical picture in the central nervous system, such as arterio-sclerosis, senile changes, syphilis of the central nervous system, etc.

The family histories of the patients are rather striking, and fall into certain groups. Case No. 1—Mother and aunt insane, the former in an asylum 22 years and still living. No. 2—Mother insane. No. 4—Sister insane, mother neurotic, history of disease in central nervous system, in maternal grandfather. No. 5—Maternal aunt insane. No. 12—Paternal uncle insane, maternal cousin neurotic. No. 13—Grandmother and mother insane. No. 14—Father insane at present, and has been eight years in asylum for the insane. No. 18—Insanity reported in ancestry (not detailed), one sister of patient was a patient in the Pontiac State Hospital with dementia præcox, catatonic form.

Case 6—No history of grandparents available. Mother of patient normal; father of patient, five brothers and several nephews characterized as lazy and cranks. Agenesis of rectum in one brother, a dwarf, two of the brothers feeble-minded, four sisters apparently normal.

Case 17—Father alcoholic "good-for-nothing," paternal grandparents, cousins, one sister feeble-minded.

Case 7—Grandfather alcoholic. Case 8—Mother neurotic. Case 9—Father always eccentric, but lived to 91 years of age. Case 10—Father alcoholic, no history of other members of the family. Case 15—Father of patient a physician, always peculiar, and at one time for three months in an asylum after chloroform poisoning and, apparently, with hysteria. Entire family of patient characterized by informant as neurotic.

Case 3—No history beyond father and mother who are negative. Case 11—No history obtained. Case 16—No history obtained. Case 19—Father of patient died in infancy of patient; the mother still lives at 63 years of age and is apparently normal. No further family history was obtainable.

Grouped somewhat loosely Cases 1, 2, 4, 5, 12, 13, 14 and 18 show insanity of more or less severe and continued type in one to several members of ascendants and collaterals.

Cases 6 and 17 show agenesia and alcoholism in parents and collaterals.

Cases 7, 8, 9, 10 and 15 show alcoholism and neurotic manifestations in parents and collaterals.

Cases 3 and 19 offer no history beyond father and mother who are presumably normal.

Cases 11 and 16 no histories could be obtained.

Macroscopic anomalies were seen in the brain and its vessels in No. 4—Inequality in the convolutions of the hemispheres, the left being smaller than the right. No. 5—Small disseminated tubercle like heterotopias of cortex. No. 11—Irregularity of the anterior central convolutions and of the left parietal lobe and many stellar and irregular depressions at junctions of sulci. No. 13—Irregular and stellate depressions at junctions of sulci and very small basal arteries. No. 17—Irregular and stellate depressions at junction of sulci. No. 18—Irregular and stellate depressions at junctions of sulci and extremely slender basal arteries. No. 7—Very small and thin cranial nerves. No. 10—Basal blood vessels extremely small. Thus rather gross agenetic disturbances of the cortex were seen in two cases: 4 and 5, lesser anomalies of the cortex in three: 11, 17 and 18 and marked diminution of size in the basal vessels in cases: 10, 18 and 13, and marked lessening of size of the cranial nerves in one case, No. 7. In all, agenetic anomalies were observed in eight cases.

Macroscopically atrophy was seen in cases 3, 8, 9, 10, 11, 12, 13 and 16. Eight cases with evident atrophy. Five cases were negative both in regard to agenesis and to atrophies.

The brain weights were not given in three cases. In the remaining cases the weight ranged from 1090 gm. to 1350 gm. in seven women and from 1320 gm. to 1570 gm. in the nine cases in men. None of the weights were excessive in comparison to the size and weight of body, but there seemed to be a relation between the weight and the duration of the disease and the age of the patient. For instance the case of acute catatonia in a woman of 21 years gave a brain weight of 1350 gm., whereas the case No. 19 with a duration of 45 years, death at 75 years gave a brain weight of 1090 gm., and the proportions seemed approximately the same in the cases in men.

The types of dementia præcox were as follows: Cases 1, 3, 4, 7, 10, 14 and 15 were catatonic in type. Cases 2, 6, 8, 9, 12,

16, 17 and 19 were paranoid. Cases 5, 11 and 13 were hebephrenic. Case 18 was heboidophrenic in type.

The causes of death varied. Death from exhaustion in acute catatonic delirium occurred in cases 14 and 15 each at 21 years of age with a duration of disease of about three months. Cases 2, 3, 5, 10 and 17 died of tuberculosis of lungs or peritoneum. Case 2 at 62 years of age after duration of psychosis of 25 years. Case 3 at 40 years, duration of psychosis 18 years. Case 5 at 39 years, duration of psychosis 13 years. Case 10 at 55 years, duration of psychosis 14+ years. Case 17 at 63 years, duration of psychosis 20+ years. Cases 4, 6 and 12 died of lobar pneumonia. Case 6 at 47 years of age, duration of psychosis unknown. Case 4 at 32 years, duration of psychosis 10 years. Case 12 at 49 years of age, duration of psychosis 27 years.

Case 1 died from ulceration of intestines from swallowing pins, etc., at 24 years of age, duration of psychosis two years. Case 7 died from duodenal ulcer at 27 years of age, duration of psychosis 4 years. Case 8 died from strangulated hernia at 62 years of age, duration of psychosis 29 years. Case 9 died from tumor of kidney at 48 years of age, duration of psychosis 29 years. Case 11 died from nephritis at 56 years of age, duration of psychosis 35 years. Case 13 died from Landry's paralysis at 51 years, duration of psychosis unknown. Case 16 died from unknown cause.

Case 18 died from carcinoma of liver and gall bladder at 54 years of age, duration of psychosis 29 years.

Case 19 was found dead in bed and at autopsy sclerosis of the coronary arteries and hypertrophy and dilatation of the left heart were found. Her age at death was 75 years with duration of psychosis of 45 years.

In studying the histopathology of the above cases they fall loosely into three groups which differ only in degree but in which the same general characters form a constant and striking picture. The members of these three groups differ frequently to a slight degree and the division is by no means an arbitrary and fixed one. On the contrary supposing a very large number of cases, one thousand for instance, the group divisions would undoubtedly disappear and a nearly continuous series would remain, starting

with those of acute type and short duration and advancing to those of long-continued psychosis with or without remissions.

The first group is represented by cases 14 and 15, a young man of 21 years of age dying in acute catatonic excitement after a duration of psychotic symptoms of about three months and a young woman of the same age, same type and duration of disease.

The blood-vessels show no thickening of coats and no cellular infiltration. The endothelial lining, however, shows a reactive tendency marked by increase in staining in the protoplasm of the cells and an occasional mitosis. Considerable lipoid material is deposited in the cells along the vessel walls.

The pia-arachnoid is not widened, but its cellular elements show an exaggerated staining reaction. Some small phagocytic cells are seen containing lipoid pigment.

The architectonic of the cortex is not deranged, but the whole field presents an unusually pale appearance. This is also true of the basal ganglia, pons and medulla. This paleness is observed equally in all portions of the brain.

The most marked change is seen in the nerve cells, especially those of the second and third layers of pyramidal cells.

In the Nissl's stain these nerve cells are pale, the chromatin is either entirely dissolved out or is present in the form of fine granules which appear equally throughout the whole cell body and are also evident in the dendrites.

The nucleus is more or less swollen, but does not show the puffed out outline and pale colour seen in so-called acute swelling, but is somewhat darker in color than normally, due partly to the same fine granular condition which is seen in the bodies of the cells. The nuclear membrane shows many folds and its outline is extremely irregular, frequently forming irregular quadrangular or triangular figures.

The nucleoli are almost constantly seen undergoing certain changes in both form and color, frequently being split up into two or three or more roundish or oval bodies metachromatic in their staining characters. (This alteration in the nucleoli has been carefully described and well illustrated in an article by G. R. Lafora in *Trabajos*, etc, Vol. XI, fascicle 1, page 59, June 1913.)

Axonal reactions are rarely seen and only an occasional cell shows Nissl's "severe alterations." Heavy deposits of lipoid substances are seen in all of the smaller and medium sized pyramidal cells. In Case 15 this lipoid substance is much better stained by osmic acid than by the scarlet stain.

The large motor cells are comparatively normal, only here and there one shows partial loss of chromatin and some fatty degeneration.

No alterations are seen in the Weigert myelin stains and in Bielschowsky's fibril stain the fibrils do not show marked changes although here and there there seems irregularity in size of the fibrillary meshwork, in the Alzheimer-Mann stain which is very differential for both myelin and axis cylinders the only changes noted in these elements are an occasional rather pale and somewhat tortuous axis cylinder surrounded by an irregular and fragmented myelin sheath.

There is a very slight increase of glia in the molecular layer, but glia cells of abnormal size, shape and color are seen in all areas. These cells frequently are small and pyknotic, sometimes with the arrangement of the chromatin forming the "mulberry" type. In Nissl's stain strands of the protoplasmatic bodies are seen in the form of fine granules and in the fat stains these are seen to be lipoid. A regressive type of cell common to all dementia præcox is noticed in the Mann's stain. It has a very small dark nucleus and many very fine short processes. In Cajal's gold stain the majority of the glia cells in the medullary substance appear as small round very black nuclei with very short and frequently no dendrites observable. In case 14 many amœboid cells some containing methyl blue granula are seen.

To resume: the marked changes in the acute catatonic type having lasted but a few months are a paleness of field, loss of chromatin in nerve cells, granular degeneration of body and dendrites, very marked alterations in the nucleus with folding and irregularity of nuclear membrane and metachromatic alteration of nucleoli, severe fatty degeneration of glia and nerve cells with many regressive changes in the glia cells and very few progressive glia changes.

The second group of cases is illustrated by cases No. 1 and No. 7, both catatonic in type, but with a duration in the one case

of two years and in the other of four years, death not occurring in a stage of excitement, but from other causes, in No. 1 from intestinal ulceration due to swallowing pins, etc., and in No. 7 from duodenal ulcer. In these two cases in addition to the alterations noted in cases 14 and 15 (paleness, loss of chromatin, granular degeneration of nerve cells, folding and irregularity of nuclear membrane), a new factor is added and that is the presence especially in the medium sized pyramidal cells of a good many cells which are shrunken and sclerosed, and many more cells are seen undergoing Nissl's severe degeneration.

The 15 remaining cases (with the exception of No. 19) show still more advanced and chronic types of degeneration and though varying considerably in degree with a history of psychosis of from 10 to 35 years may be pictured fairly well by a description of No. 10, a man of 55 years of age at death with a known history of psychosis for 14+ years of age, catatonic in type with death from tubercular peritonitis. The condition of the pia-arachnoid and the blood vessels show nothing beyond the changes described in cases 14, 15, 1 and 7.

Attention is immediately drawn to the irregular appearance of the cell layers. The field is not so pale as in the cases first described, but there are areas where the ganglion cells seem thinned out and the separate ganglion cells frequently show great irregularity in the direction of their principal axis often lying diagonally and sometimes transversely to the surface. The whole body of practically every nerve cell is broken up into a coarsely metachromatic granular mass and the dendrites have undergone the same changes and can be followed for unusually long distances by the rows of granules. In addition to this granular condition the smaller pyramidal cells are in great numbers sclerosed, with small tortuous bodies dark in color and the irregular folded nuclei also so dark in color that it is frequently difficult to distinguish the nucleus from the body of the cell. Many of the large pyramidal cells are completely fragmented, others retain a certain shape of the body, but are a mass of vacuoles.

In Mann's stain, the dark irregular nuclei of the smaller pyramidal cells, show a very curious and unusual chemical change which I believe has not yet been observed, or at least published, in regard to the cerebral cortex. In the Mann-Alzheimer stain

the normal nerve cell body stains a medium dark blue, the nucleus a darker blue and the nucleolus a distinct red. In the degenerated cells above referred to the cell body is a dark blue and the whole nucleus is a red varying from purple-red to pale scarlet. As in the Nissl's stain the limits of the nuclear membrane are frequently untraceable, the purplish or bright red fading gradually into the body of the cell. Large amounts of lipid material are still present, but in proportion to the grade of degeneration and the age of the patient, the lipid degeneration is not nearly so striking as in the earlier cases. Prof. Alzheimer remarked on this apparent anomaly in regard to lipid degeneration of the nerve cells in dementia præcox and attributed the lesser amount in later stages of the disease to the probable disappearance of lipid material which had been heaped up in the cells at an earlier stage.

I have been able to note very slight thinning of the fibres in the Kulschitzky-Pal-Weigert myelin sheath stain in some of these cases, but as a rule the loss is not sufficient to be noted in so gross a staining method. In practically all of the cases, however, the Alzheimer-Mann stain shows isolated fibres in which the axis cylinder is swollen, altered in color, and tortuous. The myelin is frequently seen clumped into balls.

In Bielschowsky's silver method I have found it, as a rule, very difficult to obtain a fibril impregnation in dementia præcox but when it is successful the network of fibrils is seen to be pushed somewhat to the circumference of the cell and irregular vacuoles are constantly seen, sometimes forming an irregular beading around the border of the cell. These vacuoles are also seen at the root of the axis cylinder and here and there on its course away from the cell body. The axis cylinder is also seen to split and become very slender at a short distance from the cell body. The large motor cells although still much less degenerated than the smaller pyramidal cells show fairly marked changes in isolated cells which are pale and swollen and contain considerable lipid material. The glia cells show great numbers of cells of regressive type with irregular nuclei, chromatin concentrated in mulberry form arrangement, etc. The number of glia cells is greatly increased especially in the third and sixth layers. There is also a certain amount of fibre increase, but never very marked. The small spider cell is always seen in the

Mann-Alzheimer stain and as a rule large numbers of amoeboid cells are also present, many full of methyl blue granula. In Cajal's gold stain for glia the glia cells appear in great numbers as rather thick irregular nuclei with extremely short or no dendrites. Some lipid deposit is seen in the glia cell bodies.

To resume we have in many respects the same elements as in the acute cases of short duration: loss of chromatin in nerve cells, granular degeneration of the same, folding and irregularity of the nuclear membranes, lipid degeneration in both glia and nerve cells, but not so extreme as in earlier stages. In addition there is much more increase in glia elements practically all regressive in nature, there is severe sclerosis of the majority of the smaller pyramidal cells with marked acidophile degeneration of the nuclei, many fragmented cells are present representing Nissl's severe changes and alterations in axis cylinders and myelin sheaths are seen to a considerable extent.

There remains to be described Case 19 which presents features of unusual interest:

The patient died at 78 years of age from unknown cause, death taking place by syncope. The coronary arteries were found sclerosed which probably is the key to the sudden death. Her psychosis began to be very marked at 33 and no bodily ailments supervened until the age of 69 years when she was found one morning unconscious with drooling and suffused countenance, and from that date she suffered from attacks of dizziness, headaches, and transient sleepiness and nausea, but without any change in the type of psychosis. An abstract of her clinical course states: From the beginning she had hallucinations of hearing. In the earlier years she expressed delusions of a persecutory nature, later vague delusions of grandeur. Her flow of thought, always incoherent, became almost unintelligible in later years. She lived entirely within herself and talked to herself almost continually in a monotone. She was a prolific writer, but in later years this writing deteriorated from intelligibly expressed ideas to a level of complete unintelligibility because of many cryptic utterances. Her speech underwent the same alterations.

On autopsy sclerosis of the basal vessels was found, internal hydrocephalus and cortical atrophy. Microscopic examination showed many small foci of arterio-sclerotic degeneration and a few senile plaques with the attendant loss of nerve fibres and great increase in large fibrous glia cells in relation to the plaques and foci. But the most marked picture was still that of dementia præcox: granular and fatty degeneration largely limited to the third layer of nerve cells, great irregularity of outline and folding of nuclear membranes, numbers of small spider cells,

all of which are in no way typical of either senile dementia or arteriosclerosis.

On consideration of the organic changes in dementia præcox, and its clinical course the disease presents itself to me as a disease with special localization in the central nervous system causing degenerative changes which may be continuous but probably more frequently are intermittent corresponding with improvement or remission of the clinical disease. There is undoubtedly some regeneration of the nervous structures involved during periods of remission, but in my opinion this regeneration is never complete and the morbid process leaves residua of lessened resistance.

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DISCUSSION OF PAPERS BY DRS. WESTON, RAEDER * AND GURD.

DR. CHENEY.—I feel that I cannot let these interesting communications pass by without a word of appreciation. In the first place I want to express regret that Dr. Raeder's excellent slides could not be appreciated under

* Dr. Raeder's paper, "Four Mongolian Idiot Brains," was not furnished for publication.

the arrangements that were provided. I think it is a distinct contribution that he has made in calling attention to the fact that the Mongolian brain presents no characteristic differential point from the conditions found in other conditions of idiocy, and that his conclusion that the cause of Mongolian idiocy is extranervous, needs to be given very careful consideration.

The question of histopathological changes in dementia præcox is of interest to me, and I appreciate the opportunity of having heard Dr. Gurd's presentation. About a year ago we attempted a review of the work of previous investigators in dementia præcox. We were impressed at that time by several facts; one of these was that it seemed rather unfortunate that a certain number of observers had not been able, or had not seen fit, to present with their anatomical findings, clinical histories of the cases, so that we were not able to interpret the anatomical changes that they reported in view of the clinical history. We pointed out also that certain cases where the clinical history was presented, might raise the question of diagnosis, particularly in cases of Klippel and L'Hermitte. It also seemed questionable in our minds whether the anatomical changes that were found in cases dying at such an old age as 70 or 75, could be interpreted as belonging to the "disease" dementia præcox. We also called attention to the observations that have been made regarding anomalies and perhaps developmental changes, and the question was raised whether these so-called anomalies were more striking than might be found in normal brains or in individuals dying of other than mental disease; and we were not satisfied that such changes were more than the average or normal variation that might be found from brain to brain. (We have no hesitation in saying that we do not know personally what a normal brain looks like.)

With these considerations in view and also as a result of the fact that much thought has been given to the subject in the Psychiatric Institute of New York State Hospitals, a plan has been evolved for the anatomical study of dementia præcox in the institute in cooperation with the New York State Hospitals. The first requirement is that the clinical symptoms and observation shall have been of such a nature as to eliminate all doubt as to the diagnosis of dementia præcox. We have considered it quite necessary, in order to have the results more valuable, to study selected cases. A case is not considered satisfactory for study if death has occurred after the age of 35, or 40 at the extreme limit, because we want to avoid confusing changes of old age, or those of arteriosclerosis. The second requirement is that a case should not have died of a chronic and wasting infectious disease such as tuberculosis or exhaustion from refusal of food; cases are considered much more satisfactory if the death has occurred suddenly from accidental cause or after an acute illness of a few days or a week. Another requirement is that the autopsy shall be performed within a few hours after death; we want to eliminate, as far as possible, the confusing pictures of post-mortem changes. It is recognized that these requirements as to unquestioned diagnosis, age, cause of death, and early post-mortem removal of the brain are so strict as to make the available cases few in num-

ber, but we are firmly convinced that it is better to investigate the brain changes in a few selected cases of certain dementia præcox than to study a large heterogeneous group of cases sometimes diagnosed as dementia præcox. A number of brains obtained under the conditions mentioned have already been received from the state hospitals and it is hoped that studies of these brains may contribute to our knowledge of dementia præcox.

DR. WESTON.—Practically all the dye was carried by the plasma. A small portion, less than one per cent, is probably carried by the cells. The total number of cases observed was 45; 28 cases of catatonic dementia præcox and 17 cases of paresis.

There are a number of interesting points that I avoided in the paper because they had no direct bearing on the particular object of the investigation. The only thing I wished to report was that under certain conditions, a certain dye was injected into the spinal canal and that in a given time the dye appeared in the urine. Much interesting information could have been obtained if quantitative estimations of the amount of dye eliminated had been made. Unfortunately most of the cases observed were in such condition that they would not cooperate and there was not enough assistance to complete quantitative work on all the cases.

Perhaps I should qualify the statement that no changes took place in the dye when it was added to spinal fluid in a test tube. It would be more exact to say that no changes, determinable by the methods used, took place in the dye.

DR. RAEDER.—In regard to Dr. Weston, I think he has defended himself adequately. And in Dr. Cheney's discussion, I was glad to hear his remarks about anomalies in dementia præcox. Recently the question of anomalies came up in the study of the feeble-minded and we were at a loss to compare them with normal individuals; the best we had to compare with were paretics, which were all cases of acquired disease, and as regards developmental irregularities, potentially average types. In the acquired cases of paresis we found a low number of anomalies; external anomalies 23; visceral 29; cerebral 27; whereas in dementia præcox they were constantly higher; external 33; visceral 45; cerebral 52. In feeble-mindedness there was an increase to external 73, visceral 58, and cerebral 75.

In regard to the Wassermann tests, they were not repeated and they were done on the serum only, but there was no evidence of syphilis found in the further examination of these brains.

I want to make clear that I did not claim that Mongolian idiocy is due to an endocrine disorder. There are changes that we have studied and we presume that they were probably of endocrinological origin from the number of maldevelopments found in this disorder.

DR. GURD.—I shall be unable to answer all the questions in five minutes, but I shall attempt it, with the exception of Dr. Williams' which would take a book to answer, when he introduces causation, which I have avoided. There are certain brief things that I might say. I think it extremely unfair

to insist on seeing a pathological picture in dementia præcox, the elements of which are not to be found in some or many other diseases. I know of no disease which is characterized so sharply as to exclude many changes seen in other pathological conditions. Even general paralysis of the insane shows marked features common to several other diseases. Every element you find in dementia præcox may be found in a large number of other conditions, but the combination of the elements is different. Tuberculosis gives entirely different changes. We are accustomed to a class of diseases that have a different picture from dementia præcox. We can by looking at one slide recognize dementia præcox.

The brain weights were taken at the time of autopsy.

In regard to diagnosis, these cases were diagnosed by one or two careful observers, and finally passed upon by Dr. Barrett, so I think they can be strictly called dementia præcox.

I think you all realize it would be impossible to give a detailed clinical history and description of even one case in 20 minutes. Someone said you would get the same pathological picture in any excitement. I question that statement.

STUDIES ON A CASE OF HYPO-PITUITARISM.

By H. S. NEWCOMER, M. D., AND E. A. STRECKER, M. D.,
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Philadelphia, Pa.*

The patient, A. C., was referred to the Pennsylvania Hospital through the out-patient clinic for mental and nervous diseases. The history recites that the father was intemperate; the mother alcoholic, immoral and possibly feeble-minded. One sister, four, is described as "backward," while three brothers and one sister appear to be developing normally. Neither of the parents nor any of the siblings show any unusual physical characteristics and are of average stature and weight. When the family was brought to the attention of the Aid Society, an almost indescribable condition of squalor, filth and utter neglect was found. Our patient was then ten years old and had never attended school.

The following items of personal history are of interest:

Eighteen months ago at the age of ten years, three months, the height was 61 inches and the weight 109 pounds, and ten months later she weighed 165 pounds and had gained two inches in stature. The Society visitor found great difficulty in keeping pace with the rapid growth and development in the matter of clothing. Adult garments had to be supplied as the waist measured 33 inches and the bust 38 inches.

Additional information is derived from the separate observations of caretakers for the Society and is here quoted, June, 1918: "The girl's appetite is enormous. She consumes half a loaf of bread at one meal and requires several helpings of everything on the table. She is gluttonous in her manner of eating and forgetful and sluggish in her movements." April, 1919: "Growing very rapidly, appetite is gluttonous." October, 1919: "Appetite abnormal and bolts whatever is given *her* with very little chewing; very sluggish in all her movements; likes to go to bed early and sleeps late and soundly."

During the two months prior to her admission to the hospital there was evidently some improvement. The patient became somewhat brighter and more interested, but at best was still slow, plodding and indifferent.

PHYSICAL EXAMINATION.

At the time of our physical examination the patient's actual age was 12 years, 2 months; apparent age about 17 years. Height 63 inches, weight 155 pounds. Head rounded, circumference 55 cm. The profile showed slight maxillary prominence. Nose somewhat saddle shaped and short. Ears large with fleshy lobules. Teeth show moderate spacing with protrusion of the upper central incisors. Neck short, girth 35 cm. Hands wide and relatively short with a tendency to slight finger tapering. Shoulders rounded and fairly broad.

Chest broad and deep—circumference 37 inches above and 38.5 inches over the breasts, which are well developed, firm and globular and with a clearly defined pigmented areola about the nipples. Pelvis straight with a tendency to the masculine type. Circumference at hips 40 inches. Upper extremities feminine in type. Girth arm 27 cm., forearm 25. Lower extremities are of feminine type. Girth of thigh 62 cm., calf 36 cm. Above malleoli 23 cm.—at malleoli 27 cm.

The anthropological measurements on the skeleton are: total height, 156 cm., height above the floor of the acromium processes 130 cm., the proximal end of the radius 97½ cm., the styloid of the radius 77 cm., the tip of the finger 59½ cm., the umbilicus 97½ cm., the anterior superior spines 94 cm., the upper border of the symphysis 85½ cm., the proximal end of the tibia 46.3 cm., the internal malleoli 6 cm. The inter-acromial distance is 33 cm., the inter-anterior superior spinous 21 cm., and the span 164 cm.

Hair: The head hair is medium fine, dark brown, rather scant and growing low over the forehead and in the temporal region. The eyebrows are scant. No other hair growth excepting a small amount on the labia majora and a scarcely perceptible down on the lower limbs. December, 1919, the menses appeared for the first time.

Breasts well developed although not fully developed for normal woman. Definite pigmentation of areola. Pubic hairs not fully developed. Clitoris normal. Hymen not intact. Vaginal examination easily made—some leucorrheal discharge—cervix palpable, rather soft and above size of virgin uterus. Ovaries not palpable.

The skin is dry, warm and slightly roughened and thickened.

Adipose tissue: There is a large amount of firm fat, more or less evenly distributed with some excess in axillae, breasts, over abdomen and in the gluteal region. It has no myxedematous characteristics.

The heart and lungs are negative.

Blood-pressure averages: systolic 123, diastolic 88.

The abdomen is negative.

The lymphatic system is normal.

The neurological examination is negative.

There are no objective sympathicotonic or vagatonic signs. The oculo-cardiac reflex is normal.

The urine is negative.

The urinary output varies from 1000 to 2500 cc.

The serum Wassermann is negative.

The temperature is continuously subnormal, often as low as 96°, and the pulse and respiration are normal.

The X-ray report shows an approximately normal sella. The radial epiphyses are open.

The eye examination shows a normal fundus and no visual defect. There is some constriction of the form field especially for the left eye and there is overlapping of the color fields. The deviation from the normal is not remarkable.

There are no psychotic symptoms. The psychometric measurement gives a mental age of 7.5 years, being a retardation of 4.5 years.

At the present time the patient while not active or alert is neither dull nor sluggish. She shows a fair degree of interest in various occupations and does well under supervision. There has been a distinct decrease in appetite and she now eats only an average amount.

EXPERIMENTAL OBSERVATION.

The sugar tolerance was determined with both sucrose and glucose. As much as 400 grams of sucrose was given without producing glycosuria and with a 40 mg. fall in the blood sugar. 325 grams of glucose did not result in a glycosuria and produced a fall of 15 mg. in the blood sugar. This fall in the blood sugar at the end of an hour is found infrequently and seems to be associated with a high sugar tolerance.

The following experiments were made to show the relationship of the sugar tolerance to the secretions of the endocrine organs. The ingestion of 225 grams of glucose with the simultaneous subcutaneous injection of 2 c. c. of pituitrin produced within an hour a blood sugar rise from 128 mg. to 256 mg. per 100 c. c., and an output of sugar in the urine of 0.9 gm. Within two hours the blood sugar fell to 148 mg. The blood-pressure remained unchanged. With the usual breakfast (toast and coffee) and two hours previous to the ingestion of 225 grams of glucose 20 grains of thyroid extract were administered by mouth. The blood sugar at the end of one hour was 149 mg. per 100 c. c. The average for the patient as frequently determined is not more than 135. There was no glycosuria.

The injection of 2 c. c. of 10 per cent boiled anterior pituitary lobe extract produced no thermic response.

The Goetsch test gave a blood-pressure rise of 15 mm. without glycosuria. During a two hour period there was an increase in white blood cells from 13,100 to 14,900 affecting the neutrophiles. A large dose of adrenalin, namely 5 mg., resulted in a leukocytic increase from 11,575 to 27,000 also neutrophilic; the blood pressure rose from 130 systolic to 175 systolic during the first hour and there were slight sub-

jective symptoms of cardiac discomfort. The urine contained 3.375 grams of sugar. The subcutaneous injection of 1 mg. of neutral sulphate of atropine produced moderate pupillary dilatation and accelerated the pulse from 100 to 115 over a period of several hours.

One one-hundredth gram of nitrate of pilocarpine resulted in a scarcely perceptible supraorbital sweating and possibly slight salivation.

The basal metabolism as done by Dr. Jonas gives the following figures: Respiratory quotient .85, total calories per hour 90.74, total calories per square meter per hour 53.7. The latter figure is 7 above the normal for a girl of 12, 14.5 above the normal for a person of her maturity.

DISCUSSION.

The patient shows neither vagatonic nor sympathicotonic symptoms or signs. She, however has a syndrome of skeletal overgrowth, pathological adiposity and unusually high sugar tolerance, which latter can be promptly decreased by the administration of pituitary extract but not so definitely by thyroid extract. Neither the character of the adiposity nor the appearance of the skin are suggestive of hypothyroidism and no other signs, with the exception of the high glucose tolerance, indicate the possibility of such a condition. The adiposity is more or less generalized. It has resulted in a recent increase in weight of 55 pounds and a present weight of 155 pounds, which is 82 pounds overweight for her age and 53 pounds overweight for her height. Referring to the Prudential Life Insurance Company tables,¹ girls of her height and of an age, three to seven years greater, weigh 35 pounds less. The highest normal weight for women of this height at any age is 14 pounds less. There is, however, a definite skeletal overgrowth. Aside from a two-inch increase in height during a period of ten months we have to consider certain skeletal measurements which compare in an interesting way with the normal for our patient's age. The ratio of the height of the symphysis to the total height is 54.8 per cent, being 4.8 per cent greater than normal. The ration for the umbilicus is $62\frac{1}{2}$, a figure which is not reached in any race. The length of the arm is $70\frac{1}{2}$ cm., 9 cm. above the normal and the ratio to the height is 45.2 per cent, 1.7 per cent above the normal. The span is $2\frac{1}{4}$ cm. above the normal. The ratio of the span to the height is 105 per

¹ Courtesy of the Prudential Life Insurance Company of Newark, N. J.

cent, 5 per cent above the normal. There is, therefore, quite definitely, in addition to a generalized overgrowth, a relative increase in the length of the long bones. If the pituitary disease had occurred later in life or after epiphyseal union, the result would have been the development of an acromegaly instead of gigantism.

There are certain minor physical characteristics which are of some interest. Of those we may mention the spacing of the teeth, the low temporal hair growth and the slightly tapering hands.

In connection with the negative X-ray findings and other neighborhood signs, Cushing¹ and more recently Timme² have both called attention to the not infrequent occurrence of a normal sella in pituitary disease of a type similar to the one here presented.

We have, therefore, a child who has developed a something which simulates gigantism and is succeeded by an adiposity together with an unusual sugar tolerance without neighborhood signs. We may presume that there was a hyperfunction of the anterior lobe, which, prior to epiphyseal ossification, resulted in skeletal overgrowth. The present posterior lobe deficiency completes the syndrome and accounts for the high sugar tolerance, the adiposity, the subnormal temperature, the somnolence and the dry skin.

EXPERIMENTAL THERAPEUSIS.

These cases are important because they present a definite indication for treatment. The first step was to determine the dose of pituitary whole gland extract required to overcome the glandular deficiency. Following the method outlined by Cushing, the dose was advanced until within two weeks the patient was taking 100 grs. t.i.d. and without sugar appearing in the urine, following the administration of 200 gms. of glucose. A blood determination made at this time, however, gave a fairly normal blood sugar curve, namely, starting with a blood sugar, before taking the glucose of 140 mg., the blood content rose in 15 min. to 181

¹ Harvey Cushing, *Amer. J. Med. Sci.*, 1913, cxlv, 313.

² Walter Timme, *J. Nervous and Mental Diseases*, 1919, 1, 460.

mg. and dropped at the end of the hour to 166 mg. The dose was accordingly decreased to 20 grs. t.i.d. Five days later, with 200 gms. of glucose, the blood sugar figures were 110, 156 and 137 mg. Two weeks later this pituitary dose continuing, a sugar tolerance test, using 150 grams of glucose gave blood sugar figures of 134, 185 and 151 mg. The patient's weight at this time was 150 pounds and these figures correspond with what one might expect in a normal individual.

If these figures do not indicate a normal sugar tolerance they at least demonstrate a normal intermediary glucose metabolism and contrast distinctly with the condition on admission. This contrast is further shown by the figures of a test made six weeks after starting treatment and ten days after changing the dose of the gland to 10 grains t.i.d. In this test, as in one of the tests on admission, 325 grams of glucose were given and the urine contained in each of first three hours respectively .22, .14, .1 gms. of dextrose and traces thereafter. This is the only time that sugar has appeared in the urine. The blood sugar figures on this occasion are even more interesting. They were 122, 200, 181 and 154 mg. respectively before 15, 30 and 60 minutes after the ingestion of the glucose.

The absence of sugar in the urine on these occasions may be attributed primarily to the fact that the blood sugar hardly rose high enough to give demonstrable sugar in a two-hour specimen. There is further to be attributed to pituitrin a certain amount of inhibitory effect on sugar excretion.*

It becomes apparent that with the increasing doses of pituitary extract which were used the method of dose-control through a study of the excretion of sugar in the urine is inadequate. At the time when a normal blood sugar curve was reached there was no urinary sugar. In fact, it seems that we had already overstepped the necessary dose of the glandular extract and it is possible that massive doses could produce a vicious circle. There could develop either an increased tolerance or a decreased kidney excretion, either of which would be difficult to demonstrate through a study of the urinary sugar alone. At any rate, following a short interval of massive dosage of pituitary extract it was found that

* Addis, T., Barnett, G. D. Shevky, A. E., *Am. J. Physiol.*, XLVI, 52, 1918

at the end of a period of several weeks of moderate dosage an essentially normal sugar tolerance had been reached. It is not possible to say whether the preliminary massive dosage or the interval of time was most important in securing this result. The question is still open as to what the best dose of pituitary extract may be for this patient.

It is interesting to note that during the early period of pituitary administration the simultaneous administration of 5 gr. of thyroid extract t.i.d. produced in three days symptoms of hyperthyroidism. There was considerable tachycardia, pulsation over the thyroid, fullness in the neck and anxiety on the part of the patient. The thyroid was discontinued.

It seems a fair conclusion to state that by the administration of pituitary extract the patient has had the two outstanding signs of hypo-pituitary disease removed; namely, the weight has definitely decreased and the sugar metabolism has become normal. Her mental condition has markedly improved.

DISCUSSION.

DR. RAEDER.—I want to congratulate Dr. Newcomer on his carefully prepared case and the advantage it has been in giving us some information on this very interesting subject. I would like to ask Dr. Newcomer if he will tell us something more of the mental state of his patient, and also anything pertinent about the relation between the hypo-pituitary state and the teeth.

DR. E. D. BOND.—There is one thing interesting in Dr. Newcomer's case which he barely mentioned. This patient wandered into a mental clinic and it took an enormous amount of work by psychiatrist, roentgenologist and biochemist to find out what she needed. The fact that this work could be done made the case turn out well.

DR. NEWCOMER.—The patient was a child sufficiently backward and troublesome to the aid society to cause them to bring her to a mental clinic. She has improved.

PLOTS IN PSYCHIATRY.

By DONALD GREGG, M. D., WELLESLEY, MASS.

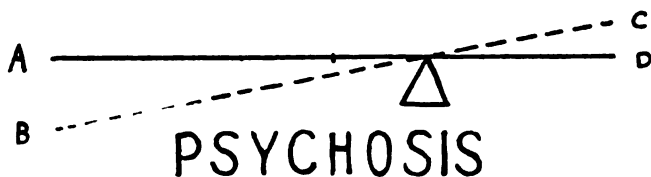
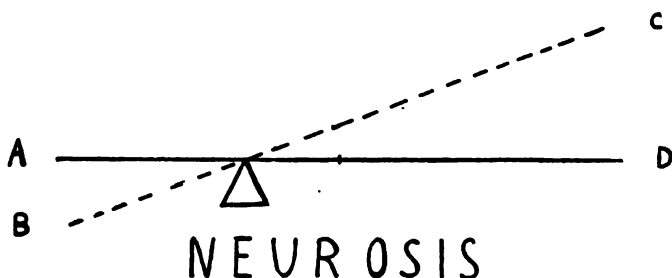
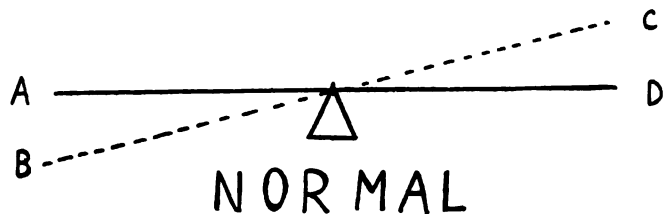
Although the title of this paper may sound somewhat Bolshevistic, its object is not to discuss any revolutionary plans but to call attention to the use of diagrammatic means for illustrating some of the ideas that we deal with in psychiatry. To many a word picture is not nearly as illuminating as a diagram, consequently any method of expressing our thoughts which is clearer than by means of a word picture should be valuable both to those to whom an explanation is being made and to the one who is attempting the explanation. Diagrams as commonly used may represent fixed conditions or changed relationships and curves may be plotted to represent the relationship of two or three factors.

In psychiatry we recognize three main fields of mental activity, the will, the intellect and the emotions, and three varying degrees of activity in each of these fields, namely: increased activity, diminished activity and lack of activity, or, in the terminology of Dr. Southard, as regards the will, hyperbolic, hypobolic and abulic conditions; as regards the intellect, hyperphrenic, hypophrenic and aphrenic conditions; and as regards the emotions, hyperthymic, hypothymic and athymic conditions.

In mental and nervous diseases two of these three fields of action are usually involved, namely: the intellect and the emotions. The will may be involved secondarily but it is seldom of primary importance in disease and consequently we can consider the varying activities of the intellect and the emotions and to a large degree disregard the activities of the will.

In the first of these charts we may consider the reaction of an individual to a given emotional stimulus. In a normal individual a given emotional stimulus should produce a corresponding emotional reaction upon the body and this reaction is expressed largely through the sympathetic and vegetative nervous systems.

In a neurotic individual however it is commonly recognized that a given emotional stimulus produces an excessive reaction. This relationship is shown in the second diagram wherein the emotional stimulus AB produces an excessive reaction CD . In a psychotic



AB = Emotional Stimulus.
 CD = Reaction.

individual however a given emotional stimulus produces usually a very slight reaction, and this situation is shown in the third diagram.

When we come to analyze the emotions we find that they are of triple origin, namely: those coming from the body such as pain of various sorts, those coming from the mind or what are commonly called worries, and thirdly those coming from the outside

world or the environment. It is recognized that pleasurable sensations may come from the body and pleasant feelings may arise from mental activity but emotions tending to euphoria play little or no part in the genesis of disease.

The makeup of the emotions is shown in the accompanying chart, in which one portion of a column depicts emotions of somatic origin, another portion emotions of psychic origin and the third portion the emotions of environmental origin.

ENVIRONMENTAL

PSYCHIC

SOMATIC

EMOTIONAL SOURCES.



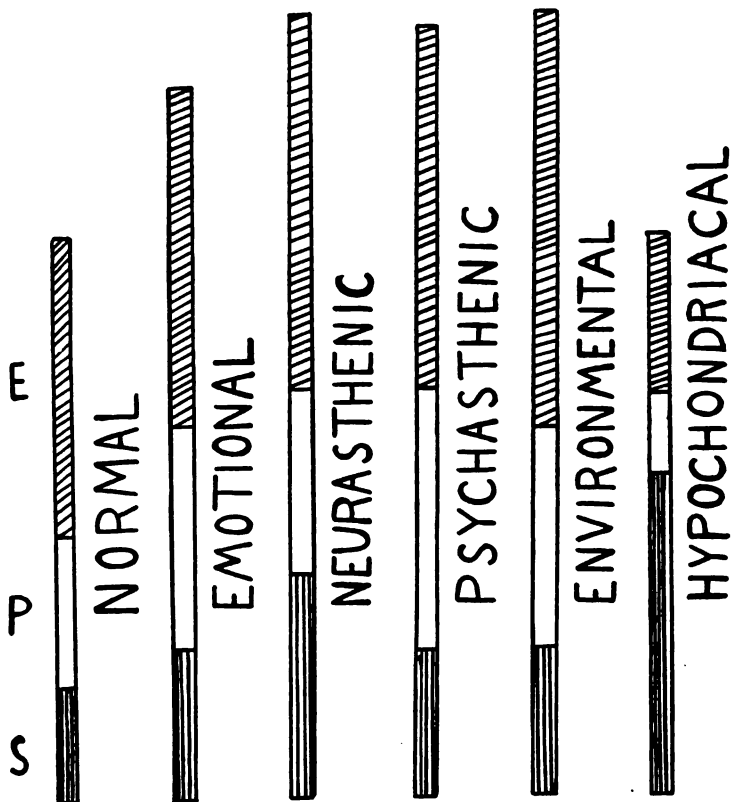
Of course it is recognized that individuals vary greatly in their emotional activities and the condition here shown is purely theoretical and qualitative rather than quantitative. In an emotional individual all three of these sources of origin may be amplified and this condition is shown in the second column.

In a neurasthenic individual the emotions of somatic origin are especially increased. In a psychasthenic individual the emotions of psychic origin are especially augmented and in an individual overtired from excessive environmental difficulty the emotions of environmental origin are augmented. These conditions are shown in the various columns as marked. In a hypochon-

driacal patient the total emotional reaction is seemingly subnormal. The emotions relative to the body are most noticeable.

In the next chart the relationship between the intellect and the emotions is shown.

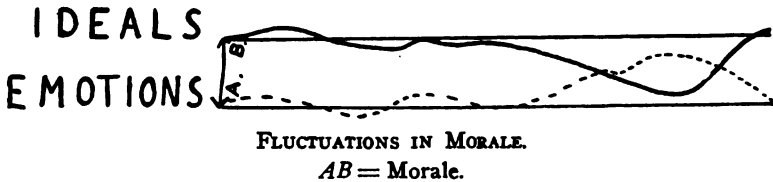
Here it is assumed that the intellectual and emotional activity may be plotted as pulse and temperature are plotted upon a hospi-



tal chart. The distance between these two lines we may think of as "morale" and when the intellectual ideals diminish or the emotional activity increases morale becomes less, just as the separation between these two lines is lessened on the chart. When the two lines converge an individual, like an army with its morale gone, is exposed to defeat. In an individual such a defeat means that the emotional activities have become dominant and are direct-

ing the individual's action, whereas normally the intellect should be the steering-wheel and the emotions should serve as motive power.

It is evident that to restore normal conditions an individual's intellectual ideals should be raised and his emotional activities decreased. To lessen the emotional activities the origin of the emotions should be borne in mind. An attempt should be made to lessen the emotions of somatic origin by correcting physical abnormalities and furthering physical health by all the means at our disposal. The emotions of psychic origin can best be lessened by psychotherapy and shifting the attention by occupations, and the emotions of environmental origin can often best be lessened by a sharp change in environment. Too often but one source of emotional activity is considered. The individual and the family often

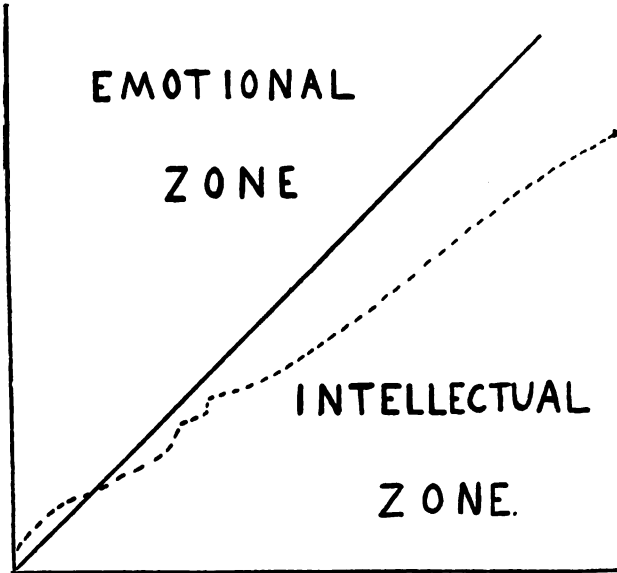


dwell upon the importance of an environmental change. The psychologist, the Christian Science healer and the teacher of New Thought regard particularly the psychic origin of the emotions and the surgeon often lays stress only on the somatic condition and disregards too much the psychic origin of emotional difficulties.

A second method of plotting the relationship between the intellect and the emotions is shown on the accompanying diagram in which the emotions and the intellect are plotted with coördinates.

Here we have an area of intellectual activity and an area of emotional activity with a boundary line drawn between the two areas. An individual starting at zero, presumably in childhood, lives a life in which the emotions and the instincts predominate as governing factors in his activities. But later in life the intellect normally becomes the guide of activities and from then on the curve of a normal individual should swing farther and farther away from the danger line where the emotions predominate over the intellect.

It is evident that on such a chart various conditions can be depicted. In a highly emotional individual the curve would not swing far from the emotional area. With a hysteric there would be abrupt excursions into the emotional field. With a neuras-



thenic the curve might run for some time in the emotional area and probably never swing far from the dividing line.

No new knowledge regarding the etiology of any nervous or mental condition is suggested in these charts but inasmuch as it has been found helpful to certain patients to explain their conditions by such diagrams it is hoped that the explanation of these charts at this meeting may have served some minor purpose.

MALINGERING AND SIMULATION OF DISEASE IN WARFARE.

By TOM A. WILLIAMS, WASHINGTON, D. C.

A chief task of the army neurologist in war time is to detect malingerers and simulators, those who imagine they are sick or hurt, also those who are beset by apprehension of disease. As a psychiatrist he knows that man in the mass is a weak creature of suggestion and ready to avail himself of any excuse to avoid difficult obligations; but, he also knows that this very weakness of humanity may be utilized to make a man, by example, suggestion, or persuasion, brave, devoted to his duty, willing to fight and even to die for his country. As a student of the humanities, he knows that this suggestion was performed in their warlike days by the ancient Greeks, the Romans, the Mohammedans and the Zulus. Furthermore, he knows that humanity has not changed, for he has seen the same marvel accomplished by the French. Thus he is ready to do his part to attain this end for his own country.

As a physician he knows that the detection of an evasion of duty is only the beginning of his task. He should know that a man interested only in diagnosis, or who has exclusively what is mistakenly called a scientific interest in his profession, has no place in an army at war. He knows that his own duty is not only to detect, but to bring to bear his knowledge to compel a change of heart in the man he has found trying to deceive in order to escape his plain essential obligation as a citizen of a free state.

The neurologist who understands his profession knows that there is no essential difference between an attempt at self-mutilation, of which even the laity can comprehend the motive, and the complicated form of malingering concealed in the ramifications of a psychoneurotic state. His knowledge and psychological skill prevent him from accepting at face value all the psychopathological phenomena which are presented to him. The army neurologist must have an insight too keen to be befogged by the possibilities

of a mass of nebulous psychopathological theories in which vastness assumes the guise of profundity, and of which the intrications appear necessarily scientific only to the unobserving. His mind is too practical to allow academical artificialities to smother his true objective, namely, the rapid return of his patient to effective duty. His morality is too broad to allow him to be influenced by pharisaical bigotry with reference to the blamability of the patient before him.

Irrespective of the genesis and mechanism of the patient's complaint, the true psychotherapist makes it his business to remove from the subject's mind the false attitude it has adopted. He tries to replace the false with a true sense of obligation towards his fellows; but when he cannot do this he is supple enough to be content to appeal to his patient upon other less altruistic grounds, and to imbue him with a feeling of respect for, and the imperative necessity of conforming to the desires of those whose sense of duty has led them to sacrifice immediate personal comfort and advantage for the good of the cause.

OPPOSING DOCTRINES.

Two contrasting opinions stand forth conspicuously when malingering and simulation are in question. One of these is that of a good many military doctors without psychiatric training who consider that every symptom for which they can find no grave physical signs is due to simulation, and that on principle every soldier should be suspected of malingering unless he can prove the contrary. The other opinion is that every simulator is proved by that very fact to be abnormal mentally, and that if he has not already manifested a distinct psychosis, it is only a matter of time before he will do so, and that he should be interned rather than punished. I have stated the extreme of these opinions in order that the reader may the more readily be struck with the absurdity of each of them. Now, as a matter of fact, it must be remembered that the psychiatrist sees almost exclusively those malingerers in whom there is already a suspicion of mental disorder, and that he fails entirely to see the vastly larger number of malingerers of whom there is no question of mental disturbance, and who are punished quickly and return to duty thereafter usually without

further manifestation, and continue to live normally for the rest of their days.

As a matter of fact malingering is a perfectly normal reaction of simple-minded persons, and is almost universal in young children, given circumstances which permit it, *i. e.*, provided that the idea of it is brought to the attention. Whereupon by direct imitation or by inductive reflection concerning illnesses observed, the malingerer fabricates a syndrome in which he attempts to make others believe, and indeed often succeeds in believing himself, more especially if he has retained the high suggestibility of the normal child. Furthermore, malingering is even more often a mere continuance of the complaint of a sickness which has in reality ceased, a profession being maintained for the comfort or justification derived therefrom. The patient finds that his lot is softened.

Now, this is not a mark of disease unless we so call the human desire for comfort, sympathy and protection from danger. As a matter of fact, this is the mechanism at the root of the symptom known in the army under the name of perseveration, and was especially conspicuous during the present war. To call all such cases unsound of mind and to condone their resistance would be a travesty of psychiatry and a forensic stupidity which would quickly demoralize any army, or for that matter any society. For although the strict determinist may argue with justice that no one is to blame for any act whatever because all our acts are determined by circumstances, yet the practical sociologist, law-maker, the upholder of order, any man of common sense, has found that in practice one of the most powerful determinants of social amenability is the deterrent to anti-social impulses provided by the fear of punishment, based upon the premise that each citizen is regarded as capable of controlling his acts so as to avoid injury to his neighbor.

When an individual has not developed mentally to the point where he appreciates the advantages of behavior which adds good to the community, to condone the means he uses to avoid his responsibility by malingering, and to attribute his behavior to a psychological incapacity is only to add to his motive the very justification which he seeks, to tempt him to further infractions

and to furnish an exceedingly injurious example to others at a similar developmental stage. The argument that such persons are irresponsible on account of their mental inadequacy is completely refuted by the effects upon these persons of the fear of punishment, which is capable of immediately cutting short their anti-social attempts to evade their obligation.

Such malingerers usually show such an insight into the advantage of avoiding punishment that once they are convinced that their dodge has been discovered they are only too glad to avail themselves of any loophole offered by the psychiatrist, so that they may return to their corps without the stigma of malingering having been placed upon them by him. It has the same effect as has a suspended sentence after a first offence and provides a strong incentive to future good behavior. In short, if a person finds that he avoids unpleasantness more readily by malingering, it is natural for him to malingere, and he will continue to do so in the care of a credulous observer, anxious to find excuses for him. But if the malingerer finds the observer sceptical and strong-handed, he soon realizes that malingering "does not pay," whereupon he adopts the natural course of changing his tune and resumes his obligations, grudgingly or willingly, according to his temperament.

MYTHOMANIACS.

But besides those who are inaccessible on account of their psychopathic inadequacies, there is another class of simulators who are pathological although not certifiable lunatics. These are the mythomaniacs as Dupré has called them. Their whole life is a kaleidoscopic series of simulations usually lacking in consecutivity, purpose or system, but occasionally becoming fixed in a unified end. They are the pathological liars. They usually perform merely for their own amusement and sometimes even from indifference. They are so careless and inexact about what happens that it seems to them of no importance whether statements are true or not. As they are persons who have never learned to control impulses, that have never developed any principles of conduct, they are very difficult to deal with, as ethical motives make no appeal to them, and some of them are incapable of making a continued effort even to avoid impending unpleasantness or even serious punishment. The mental process which occurs may be compared to that

of the dipsomaniac, in that the imperious craving finds no deterrent in the knowledge of the inevitable consequences, however serious these are known to be. It is easy to call these persons moral imbeciles, but this does not explain the mechanism of their mentality.

GENESIS.

This may often be found in the environmental conditions of their childhood. After all, their character is only an exaggeration of tendencies present in everyone, and more or less manifested in the deplorable commercial atmosphere of many large centers of population, where the highest criterion of principle is the capacity to "get away with it" as it is expressed.

A CASE OF SIMULATION.

Wounded 1914. Left projectile in head. Hemiplegia. Taken prisoner and returned as incurable by the Germans. He often complains of headache. He has a severe pain inside foot and leg, then mounting trunk and arm up to the ear—no higher. It is continuous, with exacerbations. There is also complaint of pain round the head-wound. There is complaint of slight dizziness, but he never falls.

The reflexes are slightly increased on the right, but there is no extension of the toes on stroking the sole. In the contralateral synergic test he co-operates badly. His right leg trembles when he is watched. The abdominal reflexes are equal. He walks on the end of his right toes, jerking the limb foolishly. He shows the Raimist wrist sign, which disappears when his attention is distracted. He is, however, very watchful, as he has been examined frequently by neurologists. He received no benefit either at the Maison Blanche or the Salpêtrière. He has learned to make his arms tremble, and to show a poor diadokokinesis. The tremor was arrested by the manoeuvre of suddenly making him touch his nose with both hands at once, while his eyes were closed. There is, however, a widening of the palpebral fissure.

In the induction of the mythomantic syndrome, for the common motive of vanity in civil life is substituted in warfare the more fundamental one of self-preservation. The desire for a "blighty one" becomes very strong in certain temperaments. It is only the difficulty of doing so severely enough and in a likely way, and the fear of being found out that prevents these men from mutilating themselves to escape danger. The degree to which such motives can lead men even in peace is familiar to all medico-legal experts.

But a man of this sort receives a certain æsthetic pleasure from his conduct. It would not be too unreal to call it artistic if he was a true mythomaniac of action. Even when no pleasure is received desire for escape may produce a strong enough motive which preponderates against the most cruel moral suffering.

The statement of a cured mythomaniac, illustrating the condition in childhood :

I entered school when I was five years old. Shortly before that, and for perhaps a year and a half after, my aunt and mother tried to inculcate in me a respect for truth which they felt I lacked. I was repeatedly corrected for misstating things, the misstatement being purely unconscious on my part. I did not distinguish clearly between what I imagined and what actually happened. To illustrate :

One icy morning I saw the Governor of Vermont going past our home carrying an axe in his hand. I immediately pictured him in my mind as falling on the axe. The image was so clear that not long after I told my mother that the Governor had fallen on the axe and hurt him. My mother inquired of his family concerning the accident. When reprimanded I still felt that he had fallen on the axe, but that for some reason he did not wish to have it known.

I frequently believed people had said what I felt they thought. I startled my mother by quoting to her what friends of hers had said. She knew that they had not said the things in question, but was equally confident that they had thought them. The only illustration which I remember is this :

I was playing alone and began to cry. My mother asked me what the matter was and I said that two little friends of mine had said that I could not sing and therefore could not take part in a cantata which local talent was to give. (The name of the cantata was "Mystic Midgets.") Mother spoke to the girls about it and they denied saying it. My cousin asked them if they had not thought so, and one of them admitted that she had thought so.

This patient when aged nine, realizing her fault, set about reforming herself, and succeeded in doing so after years of struggle. She now occupies a situation of trust, and although of seclusive temperament, is not mythomaniac at all.

According to Dupré, pathological mythomania often leads to vicious tendencies, or to instinctive perversions. It is a particular form of intellectual activity guided by pathological sentiments. It is no longer a game, but a particularly dangerous weapon, so much the more so if the psychopath is intelligent.

Normal mythomania appears to have a cause, a motive and is proportioned to it, whereas abnormal mythomania seems insuffi-

ciently or not motivated at all, its duration is persistent, and its intensity is out of proportion to its cause.

There are different degrees of mythomania, from simple alterations of truth to simulation fantastic fabulation.

In abnormal children as well as in grown-up psychopaths three kinds of mythomania are to be differentiated, *vain*, *malicious*, and *perverse*.

1. *Mythomania Caused by Vanity*.—All weak beings are more or less vain, a morbid desire for glory, and instinctive need of being spoken of, of acting a part, of being "somebody" drives them to lies and fabulation.

All children are vain, and weak children are particularly so. Most interesting is the case of the 12-year-old girl who came into school one day and said her mother was ill; every day she gave fresh details on the illness and its progress. She said at last, her mother was dead. She stayed away one or two days, and came back crying and dressed in black and gave details on the mother's burial. Some time after she explained her father had married again and gave new details on the wedding ceremony. It appeared unexpectedly that the child's mother was living, had been ill and lived with her husband. Inquiry proved that the child had only wanted to be noticed, and wished to wear a black dress that had been promised her for her birthday.

Very striking is the case of a young man who said he had killed his sister by filling her room with carbonic oxide gas he had himself prepared in a neighboring room; he was exceedingly proud of the fact and gave long explanations on the way he had prepared the gas. Nobody believed him for his sister was known to have died after a long illness. He at last acknowledged that all he had said was false.

Mythomania caused by vanity will drive certain individuals to automutilations, such a young girl who said she had been assailed in a train compartment, and proved what she said to be true by showing a small wound on her chest. Inquiry proved that nothing was true and that she herself had bought, a month before, the knife she had been wounded with.

Varieties of mythomania caused by vanity manifest themselves by simulation of crime, of disease, of exterior lesions and of organic perturbations.

X. was most surprised and disturbed one night when coming home on finding his wife apparently senseless in a chair, and her throat strangled with a string.

Everything in the room had been disturbed. He called for help and the victim on coming to said she had been assailed by two masked men who had taken her keys from her and had left her after having robbed two thousand francs and valuable jewels in her desk. Inquiry proved everything to be false and some days later Mme. X. owned she had simulated a crime for reasons she could not account for.

Simulation of disease may cause serious errors: A man pretends he suffered from tuberculous peritonitis and shows signs of great pain till at last a surgeon is induced to operate. Two more surgeons are afterwards induced to do the same, till at last he is found to be a simulator who only wants to be an interesting case.

N. has himself carried to a hospital and says he has been run over by a carriage, goes into the smallest details concerning the accident, says he has vomited blood, etc.; he undergoes an operation and apparently recovers health.

No accident had befallen him and all was fabulation, as the inquiry proved.

2. *Malicious Mythomania*.—Is associated with the various forms of destructive instinct from simple malice to the most atrocious ferocity, to all kinds of mystifications, to slanderous hetero-accusations, such as the case of a 19-year-old weak-minded hysteric girl who told the magistrate about three persons who had drowned a man. These three persons were condemned to imprisonment but soon had to be released, for nothing proved to be true. The girl then said her own father had drowned the man. The drama ended by a convulsive hysteric attack.

The well-known case of Lieutenant R. who was charged by Mlle. M. for having attempted rape and was condemned to 10 years' imprisonment which he effectually underwent, is a most demonstrated instance.

Attempts at rape with serious violence are as a rule the theme of these hetero-accusations.

3. *Perverse Mythomania*.—Psychopaths are led to perverse mythomania for the sake of satisfying their vicious tendencies. Often in these cases, the three kinds of mythomania are combined (vain, malicious, and perverse).

The case of Thérèse Humbert is most interesting and shows what an intelligent and clever mythomaniac can realize by fabrication. In this extraordinary case, the highest and cleverest classes of society were completely imposed upon by the effects of an extensive but really absurd suggestion emanating from weak-minded Thérèse, who was gifted with the particular qualities of an active mythomaniac and with remarkable creative power. Of a similar nature was the case which victimized Mr. Carnegie and other financiers.

It is necessary to remember that fabrication may have its foundation in what is or what appears to be true. There is often a groundwork of fact. Also the mythomaniac's appearance of truthfulness and of conviction and through surprising logical conformity between his words and his acts and a minute account of details win the confidence of onlookers and the most sceptical are forced into belief. An atmosphere of suggestion is created emanating from the psychopath himself. He himself, by a phenomenon of auto suggestion, believes everything he has invented, and thus is erected a monument of lies and errors which is the work of a collectivity and belongs to the social facts which Tarde wishes to be studied under the name of "Interpsychology."

Mythopathic activity is often unconscious and involuntary, but often also works with the help of conscience and will, specially at the beginning of the fabrication.

These factors disappear progressively without there being any change in the evolution and consequences of the morbid processes. Suggestion must not be neglected in this study, as it plays a most active part with children and psychopaths.

These weak-minded degenerated individuals have often a mental inertness, a laziness of will which leads them to follow what is suggested; timidity and vanity both often entail suggestibility.

It is hardly necessary after what has been stated to draw attention to the importance of mythomania from a legal and medico-legal point of view.

These most demonstrative examples show clearly enough the dangerous consequence of mythomania and the serious errors it leads to, with miscarriage of justice, such as condemnation of innocent persons to imprisonment, seem worse.

SIMULATORS OF DEAF-MUTISM.

Certain subjects pass rapidly from suggestion to simulation and inversely. The psychopathic process may develop in the following order: Commotion, emotion, suggestion, exaggeration, simulation, revendication, *i. e.*, a sense of being aggrieved with claims based thereon.

This evolution, which is seen in victims of accidents in civil life, is also found in those injured in war. (Traumatic Neurosis, *Journal of Criminal Law*, 1916, etc.)

The liar often ends by believing his own lies. A subject who at first simulates a contracture or paralysis with the intention of deceiving others may at length become the victim of his own trickery. Accordingly, it is well, from a therapeutic point of view, to act quickly and energetically.

According to Babinski, it is not so much a question as to whether the subject is sincere or not, but of ridding him of his disorder as soon as possible. He declares that if one proceeds with energy and knows how to gain sufficient authority over the more or less conscious simulators, the result can be attained even in accidents of long standing. This I can confirm in civil practice.

Déjérine, on the contrary, declared that these functional disorders are due to emotion, and that the subjects present the same mental state as those suffering from traumatic neurasthenia.

The special group of nervous and hysterical cases includes: Astasia, abasia, paraplegia, hemiplegia, convulsions with crises at shorter or longer intervals, rhythmic myoclonias, blindness, deaf-mutism, abdominal meteorism, certain plicatures of the spine, eructations and alimentary regurgitations.

It is a curious fact that in spite of being in the same ward, these neuropaths do not add to the neurosis that of others.

It is generally as a result of accidents caused by bombardment that these neurotic disorders develop. But in general psychic reaction is in inverse ratio to gravity of injury. Wounds which necessitate the amputation of a limb cause less neurosis. Here, as in accidents in civil life, rapid definite solutions which do not lend themselves to any contest as to the degree of the gravity of the injury are those most opposed to any outbreak of neuropathy.

On the contrary, it is usually among the slightly wounded, above all among the "commotionnés" without exterior wound, that psychoneuroses most easily appear.

The period of return from the front is propitious in the bad sense of the word to suggestive meditation. The psychism becomes absorbed in the chance of present or future disease and the solicitude of those about them often contributes to perpetuate this way of looking at themselves.

Nurses and other attendants must be taught to understand so as to prevent the memory of past dangers or loss of comrades being kept alive by the family circle with its apprehensions and fears for the future. For the self-deceived limit is easily passed, and the psychopath fixes his reaction often more consciously than unconsciously, and so sets his feet on the road which leads to simulation.

There are two groups of simulators: *Creative simulators*, viz.: Those who seek to realize by using their imagination attitudes, movements, or sensory difficulties calculated to awaken pity.

Fixative simulators are those who, having really suffered from a nervous lesion, and perceiving an amelioration, exploit and perpetuate their symptoms. They try to retain their symptoms.

A creative simulator of deaf-mutism is more easy to expose than a fixative simulator, for he has had to learn and keep up a difficult rôle for which he was not prepared.

The fixative simulator, on the contrary, has already been educated involuntarily. He has become acquainted with the symptoms of deaf-mutism in spite of himself. He has been a real deaf-mute for several hours, days, or perhaps weeks. He has really suffered from sensorial and intellectual obnubilation, knows therefore how it feels, which is an appropriate mode of behavior.

Doctors who themselves have experienced them bear witness to the nature of these post-commotional states. But the day that the psychoneurotic takes advantage of this lesson, learned accidentally, and compulsorily refuses to be cured, he becomes a fixative simulator. He is already in full possession of his rôle in which he has acquired a mastery calculated to deceive the spectator.

The creative simulator improvises, the fixative simulator repeats.

In order to carry on the deception to the end, these men must have great energy. Although they feel they have entered on a deplorable way their *amour propre* and their pride, or vanity, will not allow them to yield. Sometimes the double rôle of deafness and mutism is too much for them; then, invariably the patient admits that he hears again, but the mouth remains mute.

One of them, a very intelligent fellow, who, for seven months, had not uttered a word in public, told us, after his avowal, that at certain moments he had been haunted with the fear that he might really lose his voice or even his hearing, and that, terrified at this thought, he would go into the dark passages of the hospital, in the evening, in order to murmur over to himself numbers and words.

The anguish these men undergo is only revealed after they confess. The lot of these deaf-mute simulators is pitiable; always on the *qui vive*, living in fear of a movement of surprise, a significant turning of the head, a possible start at an unusual noise, a too expressive look, of thinking aloud, they isolate themselves, stay in bed, and instead of playing games they sit immovable and with a fixed look. The repetition of the same movement, the winking of the eyelids, the tic of the muscles, the biting of the lips are the subterfuges they make use of, not only to create a mask, but in order to pass the time and to give themselves new energy.

The pulse is often rapid (90 to 100 beats). Their hands tremble, sometimes even their whole body. They grow thin, lose their appetite and perspire easily.

If one asks one of them to show his tongue, the answer is almost always the same; he opens his mouth and points to his tongue, which remains glued to the lower part of the mouth. When they want to cough they make a peculiar clucking or a smothered, drawn-out sound.

They leave nothing to chance. Every one they encounter has to be convinced of the reality of their deaf-mutism. Even the letters they receive show that this end has been attained.

Two deaf-mutes suspected of simulation were watched during their outings by detectives, whereupon they confessed later, although one was never able to detect them in the slightest hesitation of manner or manifestation of suspicion, having become exhausted by being constantly spied upon, which weighed still more heavily upon them outside the hospital than in its walls.

Phenomena Following Confession.—The avowal is followed by an immediate physical relaxation. The transformation is rapid. The features get back their expression, the pulse recovers its rhythm, the appetite improves. They have regained their place in society.

Every subject who, without any objective verifiable disorder of the nervous centers or of the organs of hearing and speech and

without a characterized psychosis, *remains completely deaf and dumb for three or four months* may almost certainly be considered a *malingerer*.

This term complete total deaf-mutism is used advisedly.

Out of 17 cases of complete deaf-mutism observed and attended in one "service" during three months, nine subjects confessed their simulation.

In six cases the fraud was discovered by the gentle method which consists in sparing the self-respect of the subjects, avoiding all reproach, all criticism in the ward and above all the accusation of simulation before a witness. They are taken aside and made to understand the infamy of their conduct. They are appealed to on the grounds of patriotism, of their conscience, and they are given a physical or electrical treatment which *serves as a pretext* for their rapid cure.

In this way from some, at least, proof of remorse and regret for their behavior has been proffered. These men have been sent back to the army.

Some of them have written their news which shows that they bear themselves courageously in the front line.

The following anecdote will illustrate the methods of some simulators.

Having seen the futility of continuing his trickery, Private S. one morning asked leave to go out in the afternoon, saying that he was about to be cured. Now, what was the astonishment of everyone a few hours later, on reading the following in the evening paper :

Real Miracle.—At two o'clock this afternoon, when walking about the Boulevard de la Liberté, a soldier fell down in a fit. The passers by ran to his assistance and when he came to himself he manifested the greatest joy that the shock had restored his speech and his hearing, which he had lost by the explosion of a bomb, in Alsace, last August. The accident of today has given him back both his speech and hearing. We most sincerely congratulate him and those who ran to his assistance. This courageous soldier is delighted at this unexpected result. He is all the more pleased to have recovered his health, he says, as he will now be able to take his place beside his comrades fighting against the "Boches."

For eight months S. had not uttered a word, most obdurate malingering. Some time after this recovery so cleverly dramatized, he wrote a letter which is quoted in full :

"My Benefactor, I thank you most heartily for what the doctor has done to save me from court martial. I do not deserve it, but I shall do all I can to atone for my conduct, etc."

That he kept his word, a sergeant of his regiment recently gave assurance in most eulogistic terms.

But other simulators, usually those of *fixation*, remain obstinate. All persuasion addressed to their good-will, their moral sense is in vain. If determinedly applied to these men, intensive faradisation will however succeed. If it cannot be properly applied, however, there is nothing for them but the recourse of threatening them with court martial or even of sending them to be tried.

If possible the ears should first be tested and the cerebrospinal fluid examined, but it is rare to find a subject who will allow this to be done. Neither will they submit to be anæsthetized.

MANAGEMENT OF MALINGERERS.*

It is to be remembered, however, that there is a very strong temptation for a patient who is readily suffering to exaggerate his symptoms if he is the least suspicious that the doctor is going to regard them too lightly. This is particularly true in cases of sciatica, neuralgia or lumbago. This tendency of the patient makes the examiner's task sometimes very difficult, as he is in danger of falling into the mistake that the patient has nothing at all because so many of the symptoms he presents can be shown to be simulated. The best way to prevent this tendency of patients is to obtain the reputation of honestly considering each case on its merits, and to avoid the reputation of being too ready to minimize the man's complaints. Some neurologists adopt the plan of permitting other patients to witness each examination. In this way the men become impressed with the thoroughness of the doctor's examination, and with the fact that he does not ignore legitimate complaints. As soon as the men understand this they are deprived of their chief motive for exaggeration of symptoms, unless it is a case of out-and-out malingering. The case which is so difficult is when exaggeration or simulation is only an addition to real symptoms.

* See also Management of Hysteria in Warfare in *Military Surgeon*, November, 1919.

SIMULATED PAIN.

The greatest difficulty is as regards pain complained of, for here the task becomes one of proving a negative; manifestly impossible. So that we must have recourse to inferential probability. However, most malingerers complain not only of pain, but of tenderness on pressure. It is here that they place themselves in danger of being caught, for the observer can so vary the location and nature of the pressure without the knowledge of the patient that it is generally easy to show the inconsistency of a complaint without any real affection. Furthermore, local tenderness causes inhibition of movement of the part, which remains fixed in one attitude. The result is that there are modifications in the skin folds which can be detected upon inspection, and sometimes one can observe with the radioscope modifications of the joint surface. If these tests are negative, local or general anæsthesia will show whether there are fibers or tendinous retractions. In some cases electrical stimulation will demonstrate this. In all of these cases we would infer that we are not dealing with a complete malingerer.

The most difficult situation to adjudicate is that of pain in the back, whether it is from an alleged injury or simply lumbago. In the former case there should always be a point of maximum tenderness which is aggravated not only by pressure, but when the patient straightens the back after stooping. In lumbago, tenderness is either absent or diffuse, and the pain is aggravated only when the patient contracts the muscles and not as a rule on passive movements of the spine by the examiner.

COMPLAINTS OF WEAKNESS.

In complaints of loss of power, malingering is easier to detect than where pain is the issue. In this case, however, the difficulty lies in distinguishing between deliberate simulation and the affection of incapacity on account of an honest notion gained by suggestion or imagination. It is usually easy by means of suggestion or distraction to surprise the patient into making any movements the examiner desires. The genuine hysteric will thereupon continue to perform these movements when requested, the deliberate malingerer will cease to move the part as soon as he realizes what has happened.

LEGAL AND MORAL RESPONSIBILITY OF MALINGERERS.

There is great diversity of opinion amongst psychiatrists regarding the psychopathic nature of simulation. There has been an excessive attempt, more particularly in France and latterly in America, to remove responsibility from simulators, more especially when these are criminals. In England, perhaps, the other extreme has been the rule, namely, to punish criminals without reference to their mental condition unless this is glaringly disordered. Again, some psychiatrists think that malingering is a sign of feeble mental state, whereas Jendrassik insists that the malingerer is nearly always better endowed mentally than the hysteric, *i. e.*, that in order to simulate a disease it is necessary to possess an associational system of considerable complexity, which the hysteric lacks.

There are those who declare that the more experienced is the observer in the study of mental abnormalities and of the insane, the less inclined is he to give a diagnosis of malingering. But with reference to this, one must remember the unfortunate tendency of alienists to find everyone abnormal and to excuse the behavior of everyone they examine on the ground of the deviation which they always find. If this doctrine were carried out to its logical conclusion, there would be an entire end to social responsibility, for no one is free from mental peculiarities.

PREVENTION.

As a matter of wise policy, however, it is all the more imperative that those whose psychological tendencies do not enable them to control themselves by motives emanating from within should be provided with strong motives from without to comfort themselves as decent members of society. Thus, in practice, it is the very persons who are the least responsible because they have the least self-control whom it is most dangerous to society to relieve of the fear of the punishment which impends when they break laws.

These considerations are just as true in civil life as they are in the army.

At the same time, it must not be forgotten that there is a degree of disordered function which renders it impossible for an individual to respond to continuous stimuli from without, however powerful. Men who reach this degree of neurological deficiency must of course be removed from the ranks for treatment.

A STUDY OF THE DIAGNOSES IN CASES SEEN AT THE PSYCHOPATHIC DEPARTMENT AND HOSPITAL DEPARTMENT OF THE BOSTON STATE HOSPITAL.

By LAWSON G. LOWREY, A. M., M. D.,

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Chief Medical Officer, Psychopathic Department,
Boston State Hospital.*

The Psychopathic Department of the Boston State Hospital stands in a peculiar relationship to the state hospitals of Massachusetts. Approximately 40 per cent of the admissions are transferred from the Psychopathic to other institutions, either as committed or voluntary cases. The majority of the cases thus transferred are observed by us for a period not exceeding ten days, so that we see only a small part of the psychotic period. We must formulate a diagnosis and recommendation on or about the fifth day of their stay. Only rarely are we able to follow the evolution of the psychosis to anything approaching the end, but must instead base our diagnosis on history and cross-section of the mental state.

With these points in mind we have for some years been following such cases as go to other hospitals, in order to obtain some knowledge of further course and to check our diagnoses and prognoses against those of the institution which received the patient. Three previous studies have appeared: one by Southard and Stearns;¹ one by myself dealing with general statistics² and a third³ dealing with cases seen here and at Foxboro State Hospital.

In this paper I shall consider first the correlation of data in 1203 cases, including all hospitals, and then the cases seen at this department and at the hospital department of the Boston State Hospital.

I.

In my previous paper¹ I presented data dealing with 396 diagnosed cases and 23 unclassified cases transferred in the period from November 1, 1916 to June 1, 1917, showing that the other institutions' diagnosis agreed with ours in 305, or 77 per

cent. In addition I gave my personal opinion of the changes as follows:

Therefore, in 396 cases diagnosticated, there were 91 changes. Of these, 9 are left unclassified, and the Psychopathic diagnosis may eventually be proven correct. Of the remaining 82, 10 are cases in which, from the Psychopathic record, no error should have been made. In 21 more the Psychopathic diagnosis is probably correct. Three cases classed as errors are not really so. In three cases probably neither diagnosis is correct. So, if we exclude the cases left unclassified; the cases in which we are probably correct and those in which there was really no error, we are left with a total of 58 frank errors among 396 cases, or 14.6 per cent.

To this series of cases I now want to add a new group of 784 cases transferred between June 1, 1917, and June 1, 1918, to all of the state and a number of private institutions, and reported on to us either two, three, or four times. These cases with agreements and disagreements are presented in Table I.

TABLE I.
DIAGNOSES IN CASES TRANSFERRED.

Psychopathic diagnosis.	Total.	Other hospitals. Agree.	Disagree.	
Dementia precox	318	289	29	90%
Manic depressive	101	90	11	89%
Paresis, etc.	117	117	0	
Arteriosclerotic psychosis..	26	24	2	
Epilepsy	27	27	0	
Alcoholic hallucinosis	24	18	6	
Senile psychoses	28	23	5	
Paranoic condition	27	8	19	
Drug psychoses	3	3	0	
Huntington's chorea	1	1	0	
Korsakow's	10	8	2	
Toxic and symptomatic ...	11	4	7	
Alcoholic psychoses	17	9	8	
Organic brain disease	8	1	7	
Involution psychoses	4	1	3	
Feeble-minded and psychopathic	5	4	1	
Psychasthenia	1	1	0	
Traumatic	1	1	0	
Chorea	1	1	0	
Hysterical psychosis	1	1	0	
Total	731	631	100	86%
Unclassified	53	2	51	
Total	784	633	151	80%

There are several important points in this table. First our "unclassified" group represents 6.7 per cent of the transfers, a slightly higher percentage than in the previous group. The other institutions diagnosed all but two of these cases, though leaving many of our diagnosed cases in the unclassified group.

Second, we apparently have somewhat more rigid standards for including paranoic conditions in the precox group, since 19 of our 27 paranoic conditions were called precox in the other institutions. Many of these may have shown precox signs at the other institutions which were not apparent here.

The statement is frequently heard that we make too many diagnoses of dementia precox, but this is not borne out by the 90 per cent of cases in which the other institutions agree with our diagnosis of precox. Indeed the agreement is slightly greater than in the case of manic depressive, bearing out the finding in the previous paper. One cannot quite understand this discrepancy between general belief and the actual figures in cases diagnosed by us.

Finally, in 91 cases the second or third or fourth report from the other institutions returned a diagnosis agreeing with ours, though the first one or two reported had differed.

If now we combine the data from my first paper with the new data here presented, we find that 76 of 1203 cases were left unclassified by us, or 6.3 per cent. Excluding these, there were 1127 cases. The other institutions agreed with us in 935 or 83 per cent and disagreed in 192 or 17 per cent. If these cases were all analyzed according to the method pursued in the first paper, we should probably find a closer essential agreement than is represented by these figures. That is not done, since we only want gross orienting figures.

Table II shows the combined data for the major groups, including all cases.

From this table it is clear that the changes in diagnosis are by no means uniform in the various groups. Epilepsy again appears to be the disease in which the greatest uniformity of diagnostic standards obtains, and of the larger groups the arteriosclerotic conditions are again those in which the least uniformity occurs.

It is interesting to note that of the cases transferred 67.9 per cent belong in the dementia precox (41.6 per cent), manic depressive (13.3 per cent), and neuro-syphilis (13 per cent) groups.

These figures do not of course show our large series of admission in the "not insane" and other groups, since we are dealing with only about 40 per cent of our cases. We are not required by law to accept every case that physicians may wish to send in, and do exclude many cases recognized as insane and committable.

II.

Of the entire group of 1203 cases, 471 or 39 per cent were transferred to the Hospital Department of the Boston State Hospital.

TABLE II.

COMBINED DATA, ONLY MAJOR GROUPS SEPARATED.

Psychopathic diagnosis.	Other institutions.		Per cent. Agree.	
	Agree.	Disagree.		
Dementia precox	501	444	57	88.6%
Manic depressive	161	132	29	82
Paresis, etc.	156	153	3	98
Arteriosclerotic psychoses ..	48	36	12	75
Senile psychoses	46	37	9	80
Epilepsy	39	39	0	100
Alcoholic hallucinosis	36	26	10	72
Paranoic conditions	36	11	25	31
Alcoholic psychoses	27	16	11	59.3
Korsakow's	21	15	6	71
All others	56	26	30	46
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Total	1127	935	192	83%
Unclassed	76	7	69	
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	1203	942	298	

The latter is a representative institution with entirely separate clinical staff. As it is near this department and records and patients are readily available, the cases transferred to it have been chosen for intensive study. In general these cases remained in this department for more than ten days before transfer.

Of the 471 cases, 31 were left unclassified at the Psychopathic Department. Of the 440 cases classified by us, the Hospital Department concurred in the diagnosis of 369, or 83.8 per cent. Also they classified 30 of our 31 unclassified cases. Table III shows the changes.

TABLE III.
CASES TRANSFERRED TO BOSTON STATE HOSPITAL.

Psychopathic diagnosis.		Hospital department.	
		Agree.	Disagree.
Dementia precox	176	154	22
Manic depressive	76	65	11
Paresis, etc.	61	59	2
Senile psychoses	27	22	5
Arteriosclerotic psychoses	26	22	4
Alcoholic psychoses	25	17	8
Korsakow's	11	9	2
Toxic and somatic	10	4	6
F. M. and psychopathic	8	6	2
Paranoic conditions	8	7	1
Unclassed organic	4	0	4
Involution psychoses	4	1	3
Others	4	3	1
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Total	440	369	71
Unclassed	31	3	28
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Grand total	471	372	99

For the larger groups, we find agreement as follows: dementia precox 87 per cent; manic depressive 85 per cent; general paresis 96 per cent; senile psychoses 81 per cent; arteriosclerotic psychoses 85 per cent; alcoholic psychoses, other than Korsakow's, 68 per cent (the agreement in 11 cases of alcoholic hallucinosis was 90 per cent).

Although many of the cases in which the diagnoses were the same, particularly some of the cases in which the second or third report from the hospital department reversed its former opinion, are of great interest and importance, the major interest centers in the cases in which the diagnosis is changed. The following is an analysis by groups of these changes in diagnosis with the addition of my personal opinion of many of the changes. I have tried to be entirely objective in the formation of these opinions, and render an unbiased judgment.

GROUP I. DEMENTIA PRECOX.

Of the twenty-two cases in which the diagnosis was changed, 15 were called manic depressive by the hospital department. All

of them are cases in which delusional trends were very prominent during the period of the active attack. One of these is a very interesting case of paranoid mania similar to those described in my recent paper,⁴ with recurrent episodes of delusional formation and excitement going hand in hand. In three of the cases I do not believe the diagnosis of the Boston State Hospital is justified, either by their record or by the condition of the patient at the time of discharge. Two cases I believe were toxic rather than either dementia precox or manic depressive, and in one case our history and mental examination were clearly those of manic depressive psychosis and not dementia precox as the diagnosis was made. The other 8 cases represented those in which our diagnosis was not verified by the outcome of the case. Four cases were changed from dementia precox to unclassified and the outcome is still in doubt. In one very interesting case we made a diagnosis of paranoid dementia precox having at the time negative chemical and cytological findings in the spinal fluid. The Wassermann reaction was later returned positive on both the blood and spinal fluid, and a second puncture done at the Boston State Hospital yielded positive chemical and cytological findings, whereupon a diagnosis of cerebral syphilis was made; a proper one under the circumstances. This was a paranoid case of the type of syphilitic paranoid. In a post-puerperal case, we made a diagnosis of dementia precox, but the patient recovered showing amnesia for the attack. It is, of course, well known that in the post-puerperal period diagnosis is extremely difficult, especially where we are dealing with a first pregnancy and a first attack of mental disease. It is in our experience quite unsafe in such cases to make a diagnosis between dementia precox, manic depressive, and toxic delirium, since the symptomatology is much the same. In one case we made a diagnosis of paranoid dementia precox, changed at the hospital to alcoholic paranoid, although I am able to find no history of the use of alcohol in either record. The patient is now out on visit, continually reacting to hallucinations and delusions, and it seems to me fairly clear that it is a case of some other form of paranoid condition than alcoholic. In one further case in which we made a diagnosis of dementia precox on a feeble-minded basis the diagnosis was changed by the Main Hospital to mental deficiency. This girl had become quite silly, very erotic, and some character change

had been noted by her family about three years prior to her entrance to the hospital. It does not necessarily follow that this represents a dementia precox process, nor indeed that it represents any psychosis, although it is safe to say that she has an intensification of her original process in some way or other.

GROUP II. MANIC DEPRESSIVE.

Of the eleven changes in the manic depressive group, three were to involutional melancholia, and need no discussion beyond the statement that the diagnosis of manic depressive versus involutional melancholia is very largely a matter of individual interpretation in cases arising in the involution period. More interesting are the six cases in which the diagnosis was changed to dementia precox on a basis of symptomatology and outcome. One of these cases was called chronic mania by us and it is possible that chronic mania, if it exists at all, is a form of dementia precox. One other case is a very complex one which I have previously analyzed in my paper "The Insane Psychoneurotic" and I do not personally believe that either diagnosis is correct. In two cases the record made at the Psychopathic Department gives obvious evidence of a schizophrenic process such that the diagnosis of manic depressive should not have been made. One further very interesting patient, an alcoholic woman who developed an hallucinated and deluded state with marked maniacal excitement, and died in the Boston State Hospital from bronchial pneumonia and maniacal excitement, was diagnosed acute alcoholic hallucinosis at the Hospital Department. The patient had visual and auditory hallucinations, delusions of persecution, ideas of reference, thought that she was pregnant, had queer ideas about religion, thought she was bewitched, showed restlessness, distractibility, flight of ideas, and playfulness, together with alcoholic history, so that the diagnosis seems to me very obscure and to be settled, if at all, only by the autopsy.

GROUP III. PARESIS.

One case diagnosed by us general paresis on the basis of a positive Wassermann reaction on the blood and spinal fluid, with the other spinal fluid findings negative; delusions of a paranoid nature, and a considerable memory defect, in a patient who denied the use

of alcohol, was called by the Hospital Department an alcoholic deterioration with syphilis. The outside history obtained by them reveals the use of marked quantities of alcohol. The patient is now on visit and doing quite well. One can only raise the question of what the future may show. A second case diagnosed by us neurosyphilis and unclassified alcoholic psychosis was diagnosed at the Hospital Department as Korsakow's and discharged recovered. Our diagnosis was based on a positive Wassermann reaction on the blood serum and doubtful positive on the spinal fluid, protein increase and the gold reading 00123321. Another fluid done at the Hospital Department was negative, but no further Wassermann reactions were made on the blood. It is well known that in Korsakow's cases we are likely to get changes of this sort with the exception of the Wassermann reaction in the spinal fluid. Accordingly, it would seem that too much emphasis was laid by us upon these equivocal spinal fluid findings.

GROUP IV. SENILE PSYCHOSES.

In two cases the diagnosis was changed to psychosis with cerebral arteriosclerosis and in one of these our record gives a history of shock and marked arteriosclerosis, so that the diagnosis of senile dementia should not have been made. A third case was changed to manic depressive psychosis which is unquestionably correct. In two additional cases the diagnosis was changed to alcoholic psychosis, and in one of these our record is typically that of an acute alcoholic paranoid condition, and I am at a loss to decide how the diagnosis of senile dementia was made.

GROUP V. ARTERIOSCLEROSIS PSYCHOSES.

In two cases the diagnosis was changed to senile dementia. In one of these, a woman of seventy-eight, there had been a shock at 56, another at 67, and she presented at the time of examination in both hospitals evidence of arteriosclerosis and of an old hemiplegia, so that the diagnosis of cerebral arteriosclerosis seems to be correct. One other case was changed to involutional melancholia, with which diagnosis I agree; and another case to alcoholic dementia, but in this case the autopsy proved that the disease was cerebral arteriosclerosis through the finding of numerous small areas of softening and marked sclerosis of the vessels.

GROUP VI. ALCOHOLIC PSYCHOSES.

The changes within the group of the alcoholic psychoses are with the exception of two from one form of alcoholic psychosis to another; thus, two cases diagnosed chronic alcoholic deterioration were changed to Korsakow's, three others to the alcoholic paranoid type, and one unclassified alcoholic psychosis to acute alcoholic hallucinosis. In one case in which we made a diagnosis of chronic alcoholic psychosis on a feeble-minded basis the following diagnoses were recorded by the Main Hospital: (1) manic depressive, (2) manic on a feeble-minded basis; later (3) feeble-minded with an acute alcoholic episode, and a final diagnosis of (4) paranoid dementia precox on a defective basis. In a second case a diagnosis of cerebral arteriosclerosis was made, which was quite evidently correct.

GROUP VII. KORSAKOW'S SYNDROME.

In both of these cases the diagnosis was changed to unclassified. One of these was a very interesting case of a man who had been drinking fairly heavily, developed some paralytic symptoms, and fell down stairs. At the time of our examination he showed a fabricating delirium associated with a marked atrophic paresis of all the muscles of the left arm. The case was very thoroughly studied by us and discussed at several Staff Meetings with the result that a diagnosis of Korsakow's psychosis was finally made. At the Main Hospital it was left unclassified as might be expected from this mixture of symptoms.

GROUP VIII. TOXIC AND SYMPTOMATIC.

Of the toxic and symptomatic psychoses one was a post-puerperal condition diagnosed at the Hospital Department dementia precox, and our history is clearly that of dementia precox. Another was a very interesting case with nephritis, blood pressure of 252, and definite paranoid ideas. At the Hospital Department a diagnosis of dementia precox paranoid was made, and she was discharged on visit after six months residence as unimproved. She has since gotten along fairly well in the community. In this case the diagnosis of dementia precox seems to me doubtful because of the definite physical disorders, although I realize that

with a paranoid psychosis and physical disorder the two do not necessarily stand in any direct relation. In one case a diagnosis of Korsakow's psychosis was made with which, if it read "polyneuritic delirium" without specifying alcohol as etiology as is done in Korsakow's psychosis, I should thoroughly agree. Another was discharged as a psychoneurosis probably of the hysterical type. This was a very interesting case with many suggestions of hysteria in it, a queer period of amnesia and delirious periods. Another case showing marked confusion, a demented state, catatonic episodes, hallucinations and delusions along with a delirium was called an acute alcoholic hallucinosis which is perhaps correct except that it was really a chronic case, and with a great deal of delirium for a hallucinosis case. One case was diagnosed by us as symptomatic of cardio-renal disease and by the Hospital Department as arteriosclerotic dementia. This man had attacks of acute delirium and apprehensiveness and agitated states. Arteriosclerosis was present and the question of diagnosis remains one of interpretation.

GROUP IX.

Two cases of low-grade feeble-mindedness were transferred and one was diagnosed a psychosis with mental deficiency; the other dementia precox on a defective basis. This latter case was a low-grade imbecile, had been all her life, and at the Hospital Department was hallucinated, violent, and noisy, later very much quieter. She had shown no such episodes at this department.

GROUP X. PARANOID CONDITIONS.

The one case transferred with a diagnosis of paranoid condition was called dementia precox paranoid at the Hospital Department. Dementia precox is clearly indicated in the psychopathic record and this should have been our diagnosis.

GROUP XI. ORGANIC BRAIN DISEASES.

In two of these cases the diagnosis was changed from an undifferentiated organic disease to cerebral arteriosclerosis, both of which are unquestionably correct. In one we did not make this diagnosis because of changes in the gold reaction in the spinal

fluid concerning whose interpretation we were not clear. Another case was diagnosed as an epileptic psychosis with Meniere's syndrome. This is correct enough but the disorder was due originally to congenital syphilis. The final case was a very interesting one; this woman had a goitre for six or seven years without the production of any symptoms. Following a severe exposure she suddenly developed an aphasia which gradually cleared up through a period of several weeks. At the time of our examination the spinal fluid was negative. She had a double choked disc and eburnation of the calvarium. It seemed to us probable that she had a brain tumor although we could not locate it, and in fact had very indistinct signs for it. At the Hospital Department she was discharged with a diagnosis of "psychosis with somatic diseases—goitre," although her goitre remained as prominent at the time of her discharge as it had ever been, and was still failing to produce any noticeable symptoms according to their record. She has now been on visit for two years and doing quite well.

GROUP XII. INVOLUTIONAL PSYCHOSIS.

Of these three cases one was called dementia precox paranoid, another unclassified, and another arteriosclerotic deterioration. The latter case was a very interesting one of a man with some degree of arteriosclerosis and a slight deterioration. He was confused, weak, and at the time of our examination mute, resistive, retarded, sometimes blocked, dull, and disinterested. Later he cleared up to some extent and is now on visit improved. In this case I doubt the importance of arteriosclerosis in the causation of the psychosis.

GROUP XIII. UNCLASSIFIED.

Of the unclassified group ten were eventually diagnosed as dementia precox, 7 as manic depressive, 2 as paranoid conditions, one as taboparesis, one as epilepsy with psychosis, one as Korsakow's, five in the organic and arteriosclerotic group, one of these being an unusually interesting case of brain tumor with normal eye grounds, the autopsy showing an endothelioma; and three were left unclassified. One of these was left unclassified because of a positive Wassermann reaction in the spinal fluid, all other

laboratory signs being negative, in a demented and very active patient. A second was an unclassified case with a form of polyneuritic delirium of unusual origin. She had been running a temperature, had a marked nephritis, the spinal fluid changes were paretic except that the Wassermann reaction was negative, there was peripheral neuritis and a confabulating delirium. Eventually she developed a perinephritic abscess which was operated on, and she died some time later of an extensive retroperitoneal cellulitis. The autopsy excluded general paresis and tumor. The cause of the polyneuritic delirium is obscure, but was probably her infection.

One other change made was from psychoneurosis to manic depressive, depressed. This boy had been playing the stock market, had lost a considerable sum of money, and became quite depressed. We regarded him as a psychoneurotic because of his thoroughly good insight into his depression and its causes. At the Hospital Department diagnosis of manic depressive was made, based, of course, on his depression.

SUMMARY.

1. Forty per cent of the yearly admissions to the Psychopathic Department are committed to some one of the state hospitals.
2. In 1203 cases we have ascertained the diagnosis made by the other institution, together with notes concerning the condition of the patient.
3. An average of 6 per cent of cases receive no diagnosis at the Psychopathic. Excluding these, the diagnoses of other institutions agree with ours in 83 per cent of cases.
4. Of the transferred cases, 41.6 per cent received a diagnosis of dementia precox—the other institutions agreeing in 89 per cent; 13.3 per cent were diagnosed manic depressive, with agreement of 82 per cent; and 13 per cent were cases of all forms of neurosyphilis, with agreement in 98 per cent.
5. In 8 per cent of the cases the other institution disagreed on first or second report, but eventually made a diagnosis agreeing with ours.
6. Accordingly “general impressions” of our diagnostic errors are not borne out by these figures.
7. Thirty-nine per cent of the transfers were to the Hospital Department of the Boston State Hospital.

8. Excluding 31 unclassified cases, the hospital staff agreed with us in 84 per cent of cases, although in 50 cases they did not at first do so.

9. The common causes of errors in diagnosis are: (1) insufficient data, either of history or observation; (2) too great stress on one or two symptoms, particularly certain spinal fluid findings; (3) insufficient stressing of important symptoms; (4) multiplicity of signs; (5) changes in general picture of psychosis; (6) failures of interpretation.

10. The necessity for complete analysis from every possible angle is accordingly emphasized, as well as the necessity for careful and orderly interpretation of the data when procured.

11. Extensive and intensive consideration of the individual case is the great desideratum.

12. Since, with a good working technique, diagnoses can be so easily determined in all except the unusual cases, we can pay more attention to treatment than is now usually the case; at the same time bringing to bear on each case all modern methods, laboratory or other, which will aid in understanding the processes of disease.

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DISCUSSION.

DR. RAEDER.—In regard to Dr. Lowrey's paper, I believe that disease processes are live growing things and that these disease processes change at different stages. If the physical diseases change, mental diseases certainly change also. The entire picture of bronchopneumonia is not complete at any time. In the first stage it may appear like pleurisy, the second day like something else and the third day may show a full-blown pneumonia. If a diagnosis were forced to be made on any particular day or at any stage, it might be different. If a diagnosis of one condition is made at

the psychopathic hospital and another condition at the Boston State Hospital, I would like to know where the dividing line is. If you had the whole story you might diagnose the case something else. I do not see that we can say that the final diagnosis is a correct one; we must have the disease picture complete.

I would like to ask Dr. Lowry in how many cases he thinks diagnoses are incorrectly changed from the original?

DR. LOWREY.—In answering the question with respect to how the changes were justified, I think I neglected to mention that one of the reasons for changing a diagnosis is that some of the disease pictures do change and clear up with a perfectly good insight.

I cannot answer Dr. Raeder's question offhand. I might say I discovered 37 cases in which first changes were incorrect; about 20 per cent of the changes were not justified, and in an additional small percentage of the cases it was quite clear that neither diagnosis was correct; in three cases the psychopathic department had made a diagnosis not justified by the records of the individual case, so that certainly some of the changes in diagnosis are not justified by the record of the case or by viewing the case at the time, in my personal opinion.

A REVIEW OF THE FIVE-YEAR PERIOD FOLLOWING ADMISSION IN ONE HUNDRED AND ELEVEN MENTAL PATIENTS.

By EARL D. BOND, M. D.,

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The histories of all of the 111 women admitted to the Department for Mental and Nervous Diseases, of the Pennsylvania Hospital, in the hospital year 1914 have been traced for the 5-year period following admission and shown in three charts. Concrete facts, not statistics or percentages, are the result.

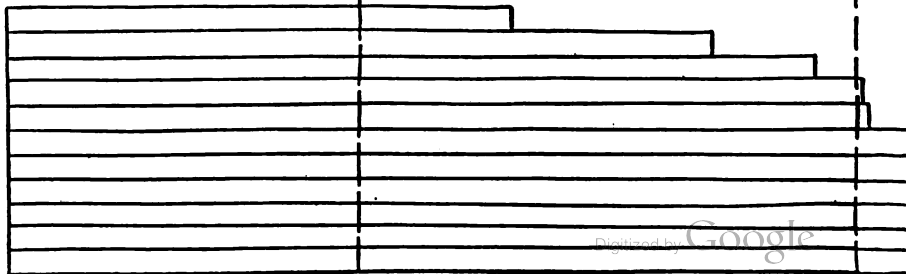
Chart 1 shows the duration of residence in this hospital for each patient, the 6 patients who remain here after 5 years coming first. The first 10 patients average $4\frac{1}{2}$ years; 101 patients average 6 months; all average 11 months. The hospital has spent more time units on the first 11 than on the remaining 100 patients. Forty-seven patients left the hospital in less than 3 months.

Short residences, acute cases, are found on the admission wards of every mental hospital; they attract interns and assistant physicians; they bridge the gap between the insane and the ordinary medical case. They should be advertised. The Dean of the Medical School nearest the hospital furnishing the record said that he supposed the average residence was several years. The same tendency to overestimate is shown by medical leaders near any hospital for the insane, and prejudices medical work.

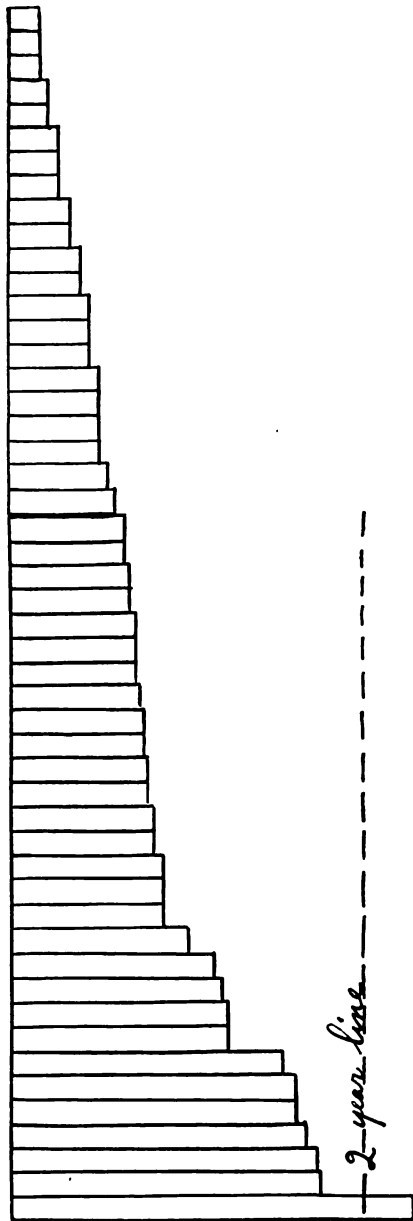
Chart 2 is a classification by results. Black indicates psychosis; the black line partial recovery; white full recovery.

Do patients stay cured? The first group (A) shows full recoveries maintained from 2 to almost 5 years. Twenty-eight women who became insane in 1914 have in the ensuing 5-year period wasted 23 years but won back 110 years of normal living. And these are genuine recoveries, maintained long enough to demonstrate their usefulness.

11 Cases :



50 Cases



2-year line

50 Cases



4 months to 2 weeks

5-year line

A contrast comes in the next cases (B). Sometimes the condition of one of them for the moment has justified the label "recovery," but the result is of little practical value. One patient may furnish a hospital with several "recoveries" each year. Nevertheless, half of these 27 patients have lived at home without special care; one of them has substituted as a high school teacher; one has done good work as a nurse. Because of inadaptability, irritability, a lack of some good quality which they once possessed, they are strikingly differentiated from the effective recoveries of group I. The worse half of this second group has been a dead weight on the community, though all have shown a tendency at some time or times to improve. Eleven, after improvement, have relapsed into conditions as bad as those for which they were admitted.

The remaining 56 patients (C) (D) have not shown any progress toward recovery. Twenty-three have died. Six remain in this hospital; 22 are in other hospitals. Five are unimproved at home.

It does not follow that the hospital has done poorer work on these cases than on those who made recoveries. A woman who for several years was tied to bed and masked is out of restraint and out of doors, but she is not less demented. Old ladies are included who were disorganizing their homes and who have been made comfortable while their families were set free to lead normal lives. Definite diagnoses were made in many cases after an observation period, and these enabled families to make definite plans for a chronic illness with a clear conscience.

Scattered through the chart are 26 deaths. Thirteen of these occurred at the hospital, 10 from recognized and chronic progressive diseases (cerebral arteriosclerosis, general paralysis, pellagra) and 3 from unknown causes. Luckily all the latter were covered by autopsy. The first showed embolism from an infected uterus in a patient admitted with fever and chorea. The second showed new vegetations on the mitral and aortic valves of a patient admitted for the fifth time with manic-depressive psychosis. The third autopsy, on a woman with a history of "liver trouble," abdominal pain, vomiting, extravagance, auditory hallucinations, bloating of abdomen, inarticulate speech, and with findings on

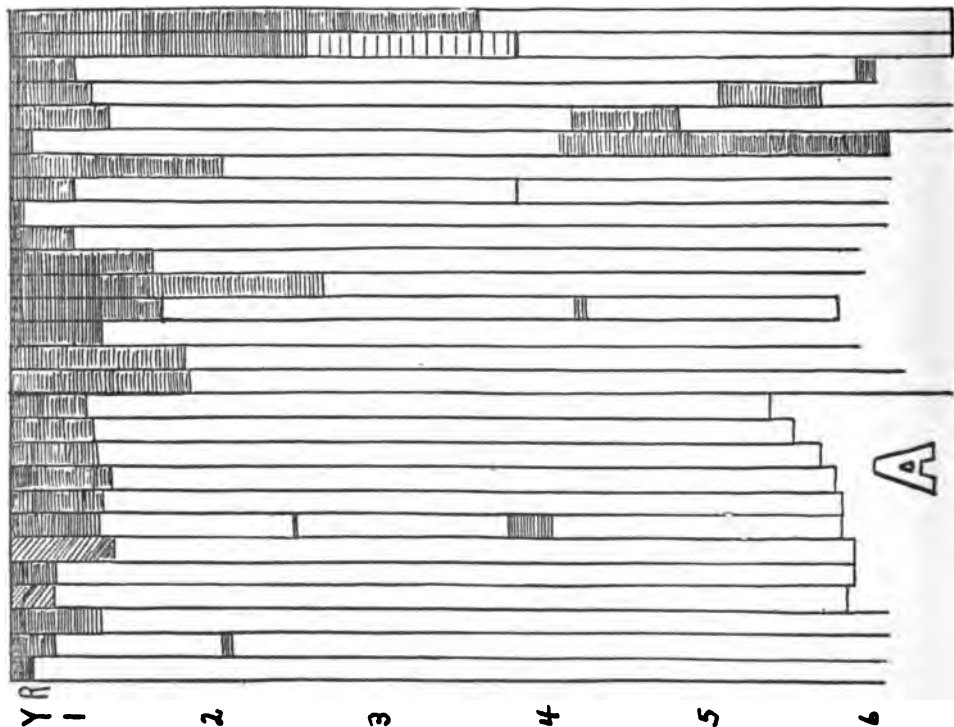
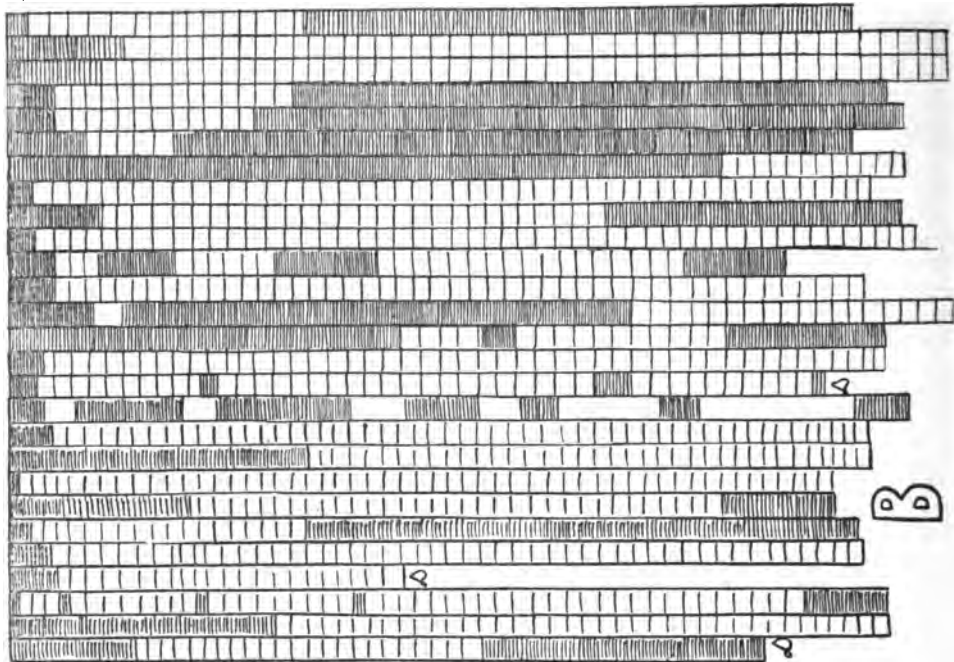


CHART II, PART I.

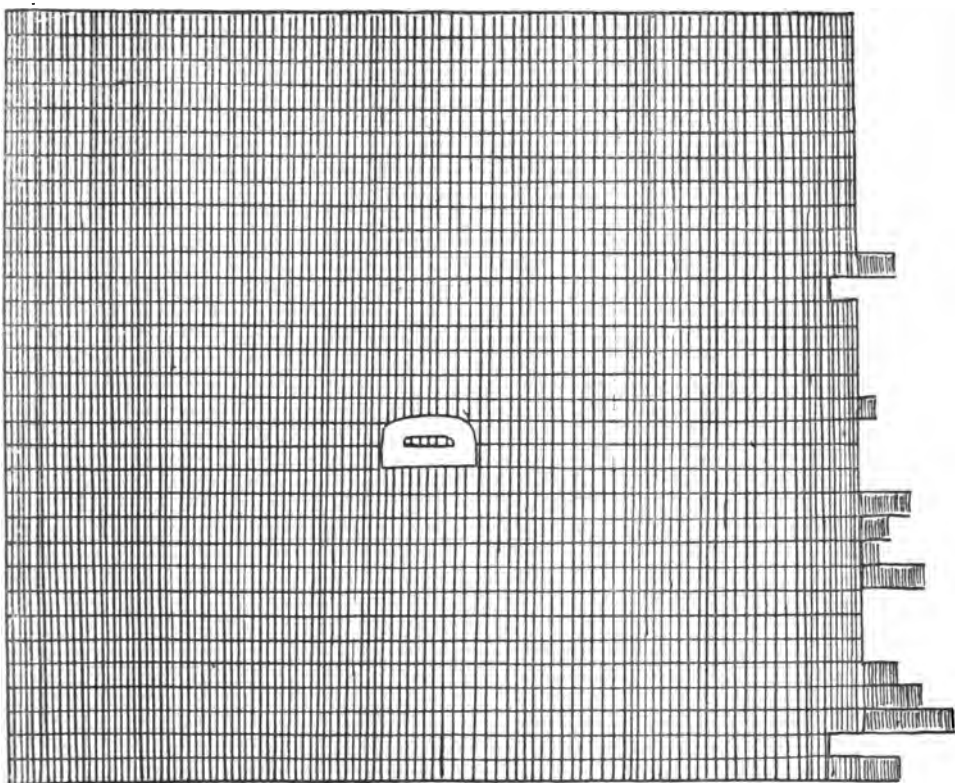
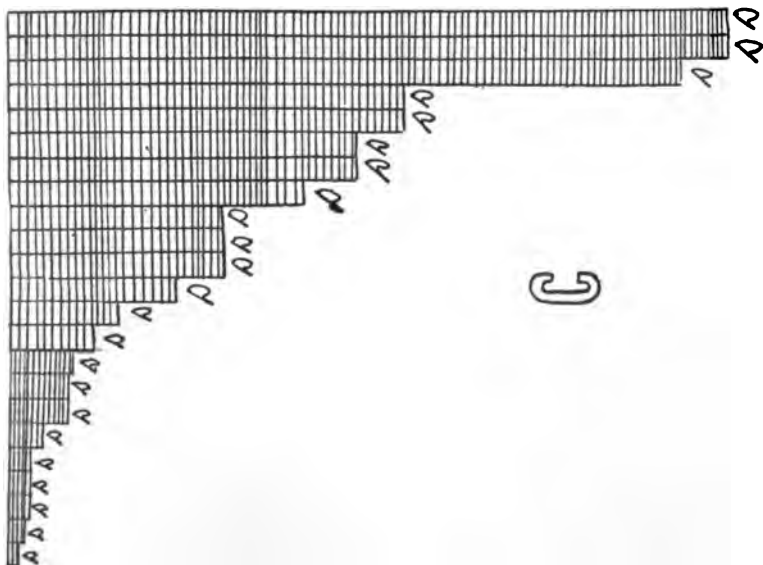



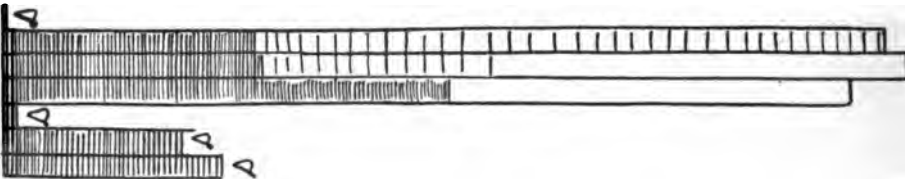


CHART II, PART 2.



Ep. M. 
 Ep. 
 ID 

Somatic 

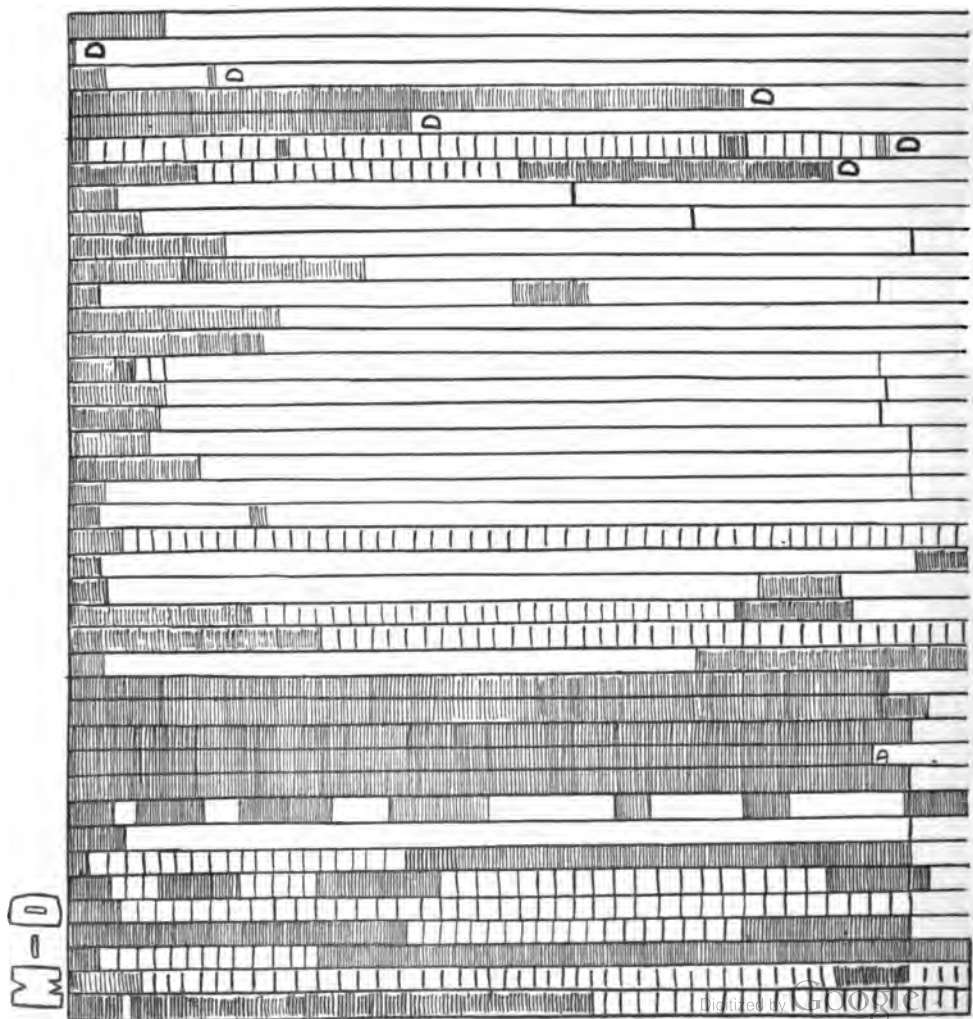


CHART III, PART I.

DP

On

Bayko-
patis

Senile-Art

Unclused

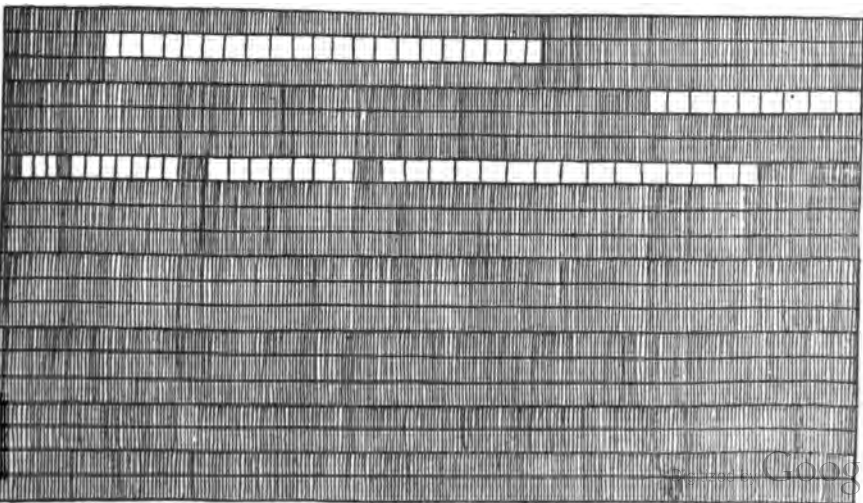
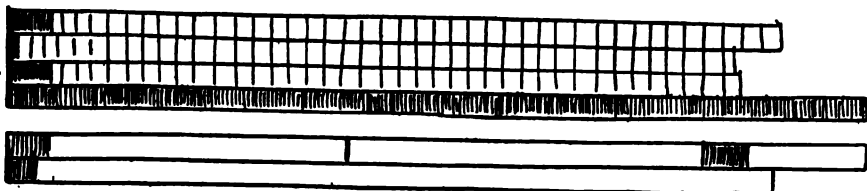
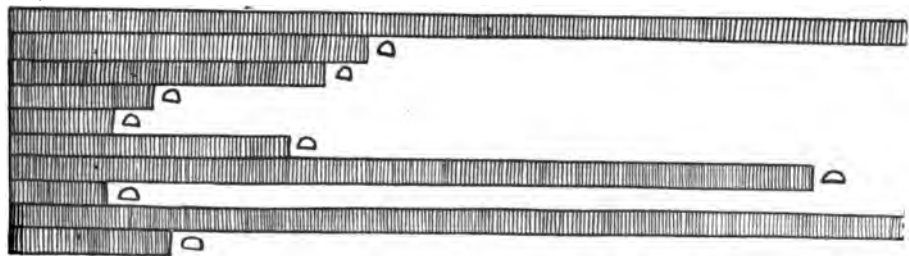
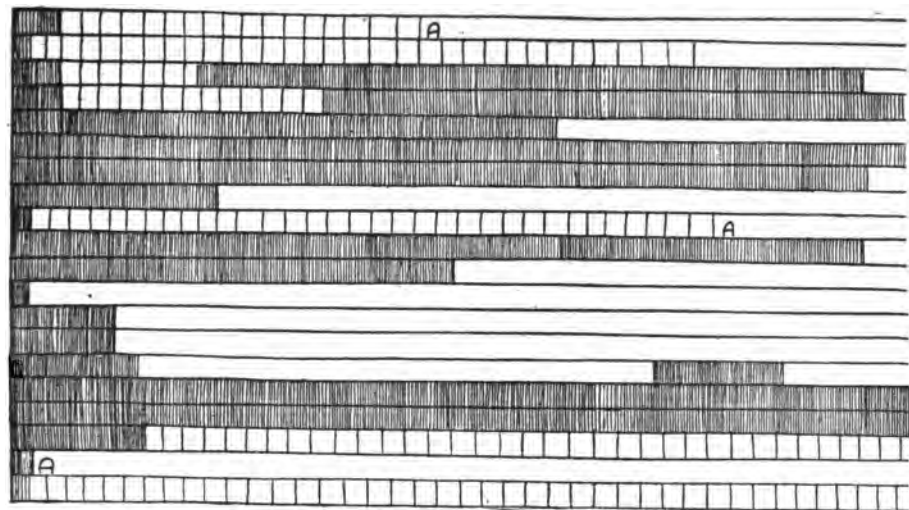


CHART III, PART 2.

admission including positive Babinski, wrist and ankle drop, visible intestinal peristalsis, athetosis, convulsions, inequality of pupils, brought nothing to light which accounted for her death or explained her symptoms.

The deaths which occurred in the 4 or 5 years after leaving the hospital naturally had a great variety of causes. Diagnoses were made at the hospital of gross brain lesion (3), carcinoma of uterus, nephritis, senile dementia, in patients who went home before they died. One patient came in with unhealed surgical incisions in abdomen and over the sacrum and was doing remarkably well in continuous baths when she was taken home and died. Two patients with manic-depressive psychosis were taken home, did not improve, and died in 4 and 2 years of unknown diseases. Three others with the same diagnosis recovered but died in subsequent attacks.

A rearrangement by diagnosis in Chart 3 shows first 20 cases of dementia præcox with all but one under hospital care after the 5 years—that one is precariously maintaining herself outside, improved but with no insight and retained delusions. Only 2 beside were able to leave hospital care for a short time.

The next groups, the senile-arteriosclerotic and psychoses with different varieties of somatic disease show clearly that the deaths in the hospital were planned for in the admissions. Ten patients with senile and arteriosclerotic dementia were received at an average age of 76, besides one patient with general paralysis and two with carcinoma.

From the manic-depressive group of 41 there have come 20 recoveries and 8 who show no sign of improvement. The remaining 13 show less than full recovery maintained long enough to be useful and range from a woman with one or two attacks a year who has decided to remain at the hospital during the intervals to a patient who came out of a manic phase, took up her housework with an access of irritability for 6 months, had another attack, got a temporary balance, and subsided into a 3½-year attack.

The unclassified, as always, furnish the most interesting group and will be abstracted individually. The "paranoid" cases are here, one of whom furnishes the most striking recovery; depres-

sions in several women over 50 were included because of the entrance of symptoms pointing vaguely to brain lesion. Individual abstracts follow, with striking details emphasized.

At 55 an atypical depression; 5th attack, no insight since but she has been self-supporting and doing good church work for 5 years.

At 40 abdominal, neurological and mental symptoms as described above under deaths, none of which were explained by autopsy.

At 28, 10 weeks after childbirth, an apprehension depression featured by "nightmares" and screaming spells: inaccessible; talked in English. Improvement in 7 months resulted in her going home where she has remained although never considered normal.

At 28, 11 weeks after childbirth, apprehensiveness, confusion, ideas of persecution, auditory hallucinations; after 6 months a sudden exhilaration followed. She managed to get on at home for 11 months and then was sent to a state hospital where she has remained.

At 47 admitted for an exacerbation of vague paranoid delusions which dated back many years. Remained 2 weeks: at home since unimproved but not needing care.

At 37 a second attack of atypical excitement with recovery, was followed by 4 years normal life, another excitement of 5 months, recovery. (In the 6th year, 1920, another attack with recovery.)

At 12 incoherence, auditory hallucinations, and suicidal attempts followed seeing her mother forcibly taken to a hospital. Recovery in 4 months. Is now in high school, doing well.

At 51, second attack, apprehensiveness and suspiciousness with deafness. To state hospital where she is now in a catatonic state.

At 35 sudden delusions of reference and persecution; then confusion. In 5 weeks recovery with amnesia, maintained fully for 5 years.

At 23 sudden disorientation, catalepsy, unimproved here in 3 months; recovered in state hospital after another 3 months; remains well.

At 58 forgetful, irritable, depressed. After 5 months residence went home and from there to residence in state hospital to date.

At 29 a restless depression with mannerisms improved and went home in 5 months; where she remained a year. She then went to a state hospital for a year, improved and soon died at home of an intermittent disease.

At 47, vague paranoid condition began which has required hospital care ever since.

At 22, delusions, resistiveness, mutism; after 2 months she was taken home for a two years' stay, unimproved and from there taken to a state hospital.

At 42 a vague paranoid condition for 4 months with distractibility, tremor, with a considerable improvement for a year and then subsidence into her former condition to date.

At 34 for 6 months before admission, delusions of persecution and reference were built up with desperate suicidal and homicidal attempts;

hysterectomy was done. Here she had somatic delusions and auditory hallucinations; ate dust and dirt: showed mannerisms. Leaving this hospital after 4 months she grew worse at a state hospital until she had typhoid fever, which diminished her excitement. Her mother took her home depressed, resistive. Her husband became interested in another woman. On being told of this, the patient recovered and has remained well for 4 years since showing better judgment than ever before.

At 21, excitement with auditory hallucinations, at hospital inaccessible (no English), tube fed, resistive. Taken home, to a state hospital, to a private hospital where she recovered after 2½ years. She has done her work and home since and is fully recovered.

At 48 a third attack of a paranoid, depressed condition. During the second attack a right sided hemiplegia was described. She got on fairly well at housework at home for 4 years till her death of pneumonia.

At 55 dizziness, elation and depression by turns. Here for 2 months paraphasic: temporary recovery for 3 months followed by residence in state hospital 4 years. Alcoholic excesses reluctantly admitted.

At 67 a second attack of depression (the first at 63). She recovered in 3 months and remained well 2 years, when she died of heart failure.

SUMMARY

The group of cases followed for 5 years is small but unselected. It constitutes a fairly acute medical service. Twenty-eight of 111 admissions have made recoveries which they have held from 2 to 5 years, a total of 110 years reclaimed. Deaths were in general accounted for by obvious conditions on admission—including old age. Dementia præcox cases are still in hospital.

Looking backward, the story of each individual has made us wiser about the outcome in any given instance. Looking forward, these life sections give us a standard by which to judge new therapeutic measures. It is evident that a new treatment will find it hard to show results with the recovery group (A) and with the group of deaths (C). We shall await a procedure which will make complete a partial recovery and stabilize those who cannot keep a good balance (B), and which can save those who nowadays go from year to year "unimproved" (D).

DISCUSSION.

DR. C. B. BURR.—Dr. Bond intimated that his paper was not important, but I would not let anybody, except himself, belittle it in my presence. I think it was very good.

DR. BRUSH.—I congratulate Dr. Bond for carrying on a series of observations of the patients after they left the hospital. There is nothing that promises greater value in our understanding of these cases than the present attempt to follow them up. We have done something of that sort at Sheppard & Enoch Pratt, not as thoroughly of course as Dr. Bond has carried it out. Sometimes we found difficulty in getting replies from queries sent to patients, but we have gotten a great deal of valuable information from patients in this way: we have sent them for many years a Christmas card or greeting of some kind and they reply to these, some of them, much more fully than you would expect, giving us pretty good information as to how they have done in the past year. These letters are put in the case records. I congratulate Dr. Bond upon the fulness of his work and in giving us an example of what he is doing.

DR. COPP.—Some of my managers repeatedly ask me what are the results of spending so much money; are there any more recoveries? Is it worth while? I presume every superintendent is asked the same questions. There is a prevalent idea that there is not much use in treating mental disease.

One of the purposes Dr. Bond has in view is tracing the life history of these patients so that such questions can be answered in a definite way. I think it is quite worth while. If we can answer these questions to satisfy the practical man we shall get more money to spend for our patients.

DR. H. W. MITCHELL.—The results reported by Dr. Bond in the eventual termination of cases recalls to my mind some observations reported to the New England Psychiatric Society. At this meeting a symposium was held upon dementia præcox and in three Massachusetts hospitals, Worcester, Danvers and McLean, similar studies were made upon the end results in cases of dementia præcox. All cases reported had been under observation for a considerable period of years and none, if I remember correctly, less than five years from the time of occurrence of symptoms necessitating commitment. There was a striking similarity in the results reported from these three independent sources. I remember that the figures from the Danvers Hospital showed that less than 3% of the patients studied were living at home with their relatives and showing no evidences of mental deterioration. A further careful study of these few cases showed that many of them were unquestionably manic-depressive in character and that there had been a considerable divergence of opinion on these cases at the time of hospital residence. Profound terminal dementia was noted in a very considerable percentage.

The extent to which hospital attention can prolong the useful period of this group of cases can hardly be determined. Sympathetic oversight and careful supervision of the matter of useful employment and regular living is, we all believe, an important factor in the conservation of a certain percentage of the person's original capacity but other factors are operative and anyone with considerable experience extending over a period of years with a given group of cases, knows that despite everything which medical

attendance may do, some patients deteriorate rapidly and are not materially influenced by external aids. Deductions drawn from observation during a brief period in the course of this psychosis, or, perhaps it would be better to say these psychoses, may be misleading.

As suggested by Dr. Sanger Brown, in endeavoring to develop a plan for obtaining the life history of syphilitics, so we must have a life history of dementia præcox cases in order to form an accurate concept of either the extent of the deterioration process or the effect that our supervisory treatment may have upon its course. Certainly an observation that does not extend over many years gives one a very imperfect basis for estimating the ultimate effect of the psychosis upon an individual.

DR. BOND.—I cannot go into details as to how these records were obtained, but the only excuse for presenting such a small number of cases in comparison with the number which could be furnished by state hospitals, is that each one had an interested family who placed the patient at our hospital and we could follow up all cases. Also we were not bothered by state boundaries. We got a great deal of help at the central office of cases admitted to other hospitals. We made a chart of patients admitted in 1841; good recoveries were frequent as they are now, but whether they remained well or not no one knows.

REMARKS UPON UNDIAGNOSED CASES, CHICAGO STATE HOSPITAL, 1919.

By CHARLES F. READ, M. D., CHICAGO.

The classification of mental disorders, other than those of grossly organic types, can never be an entirely satisfactory procedure, nor is it always a necessary one provided the examiner is alert to the situation and in touch with the great movements in the mental life of his patient, their origin, trend, and development.

Institutional practice, however, for statistical purposes, demands classification of as many cases as possible, though in complying with this demand there is no doubt but that too many cases are fitted into genera and species by a *tour de force*.

At the Chicago State Hospital, 1900 patients were admitted in the year 1919, 146 of whom were left undiagnosed when presented before the medical staff. Of these cases, the author (with the assistance of Drs. Rotman and Ewerhardt, of our medical staff, in a number of summaries) has analyzed 66 and tentatively offers the following comment.

SEX.

Of the 66 cases, 22 were male and 44 female. Our admissions during this period ran in the proportion of 11 men to 8 women; and it may fairly be asked if some of this preponderance of females left undiagnosed is not due to emotional oscillations more varied in coloring and more complex in character than in the male, and for this reason more difficult of interpretation.

AGE.

There are few below 25 and none over 60; accounted for, no doubt, by the fact that the pronounced organic types were very naturally excluded, along with the feeble minded and the simpler types of præcox reactions in the very young. The great bulk of

the group lies between the ages of 25 and 50, where stressful psychogenic and somatic factors are most active.

NATIONALITY.

Contrary to the writer's expectation only 24 were foreign born, of non-English speaking races, and few of these could not speak enough English to be understood. Fifty per cent of our admissions are foreign born.

HALLUCINOSIS.

Forty cases showed no hallucinosis or left its presence a matter of grave doubt. Whether this proportion of almost two to one is in accord with that of other admissions, the writer does not know. Possibly it indicates that the absence of this symptom contributes to uncertainty of diagnosis where other symptoms are confusing. Out of 14 cases that sooner or later showed a well marked præcox symptom complex, nine were without hallucinosis when first presented. Though hallucinosis is not at all essential to the picture of this psychosis, its presence very possibly has something of the same reassuring diagnostic effect possessed by a positive Babinski in an obscure organic case.

RECOVERY.

Of the 66 cases, 19 were discharged as recovered after a few months of hospital residence and the usual period of parole; very nearly 30 per cent. Our average percentage of recoveries to admissions for the year of 1918 was $8 \frac{1}{10}$ per cent. Sixteen of the series were discharged improved, four unimproved, eighteen remained in the institution, and nine have died. Among those discharged as recovered were a number of psychogenic depressions, only two or three frankly manic reactions, three or four alcoholic cases, two who were very possibly never insane, and several with mental upset very probably preliminary to a more frankly præcox outbreak.

ANXIETY STATES.

There were a large number of cases in which apprehension and anxiety figured more or less conspicuously. Several of these

were probably alcoholic and some without definite etiological factors.

Case No. 7 represents this type fairly well: a colored woman, aged 50, admitted with a history of having been melancholy at times for years, became rather restless, thought people were following her and that they would try to cut her fingers off. When admitted she was resistive but would answer questions, denied hallucinosis, and had to be spoon fed. In a few months she had cleared up, was jolly and cooperative about the ward, and was said to have good insight, though there is no detailed account of this. The case was left undiagnosed because it was said that the pupils were sluggish and the knee jerks exaggerated upon admission.

Another patient, No. 18, a man of 35 years of age, four months after an attack of influenza suffered an acute attack in which he smelled gas, became afraid that he was to be killed, heard people talk about it, wandered about and seemed confused. Later he performed odd actions without explanation; said that he felt "doped" and that at times his mind was blank; that he could not think, etc. Still later on he ate poorly, lay with his eyes closed, was impulsive and violent; seemingly a case of dementia præcox with a fear reaction of considerable intensity, left undiagnosed because of the apparently toxic character of the onset. He was later discharged, improved.

Case No. 34, a woman, single, 26 years of age, suffered an abrupt onset in which she walked up and down calling for her mother, but could not explain why she wanted her; later developed ideas against her father and stopped talking. Physical examination was negative. When admitted she continually twisted her hair and rubbed her hands. No particular mood was evidenced but the picture, upon the whole, suggested a stereotyped agitation. Recovery gradually took place, together with some insight, but with little explanation. The case was probably one of catatonia, but in the presence of signs of agitation it was thought wise by the staff to leave the case open.

Too often when patients clear up, a katamnesis that might shed much light upon the mechanism of the attack is not obtained and the case is left an open one until readmitted.

DEPRESSIONS OF PSYCHOGENIC ORIGIN.

A number of cases of depression with considerable apprehension and of well marked psychogenic origin do not group satisfactorily under manic depressive, involutional melancholia, nor the anxiety neuroses.

Case No. 42, an Italian, aged 32, was an ignorant but hard-working man who never failed to send money to his wife in Italy, from whom he had

been separated six years on account of the war. He was a moderate drinker. After being held up and beaten he developed ideas that people were after him and was committed. Physical examination was negative. He was timid, but evidenced no behavior disorder and delusions, nor hallucinations. Many of the members leaned toward the diagnosis of a preliminary flurry in the development of dementia præcox. The patient left the hospital a month later apparently well. No one can say whether or not he will later develop dementia præcox, but there is basis for an argument on behalf of an anxiety state based upon long separation from his wife, capped by a mental and physical shock.

Case No. 15, a widow of 56, after a frustrated love affair and under the strain of worry over a son in the army, developed apprehension; thought her children were murdered, became agitated and continued in this condition *four years*. Physical examination was negative, save for a blood pressure of 190°. Because of her age and a questionable amount of confusion, she was diagnosed as "presenile" but rapidly improved and was finally discharged recovered. When visited a year after discharge, she was found to be in excellent condition, helping with the housework in her daughter's home.

Case No. 58, a young man of 31, German, intelligent, formerly a sergeant in our regular army, was married six months before commitment and shortly after his discharge into the reserves. He did not do very well in civil life and began to fear that he had infected his wife with syphilis acquired prior to marriage. In spite of his wife's knowledge of this actual infection their relationship apparently remained a congenial one. He was finally committed because of a determined attempt at suicide by gas. At the psychopathic hospital he was said to have been rather indifferent, to have heard voices and to have felt electricity in his bed. When examined here he declared that he had attempted suicide because he had infected his wife. He denied hearing voices. Physical examination was negative, save for a positive blood Wassermann; spinal fluid, negative. Patient improved very rapidly and was discharged recovered.

No. 50 is a somewhat similar case in a woman of 36, hereditarily burdened, who had reached only the third grade at ten. She had had several induced abortions, Neisserian infections and a laparotomy with consequent premature menopause. In 1917 she blamed herself for the infection of her husband (with apparent reason), confessed to him her various indiscretions, became very jealous and developed the idea that there were worms in her blood; that they would eat her up; that God would punish her, etc. For a year and a half prior to admission she clung to these ideas with varying tenacity. When admitted she was restless and agitated, but talked readily and later adapted herself well to the institutional life and was discharged, very much improved in a few months.

In this last case the examiner suggested manic depressive, while others contended that the patient's statements were too fantastic

and that the case was probably one of dementia præcox. It was pointed out, however, that she was merely voicing her own ideas of infection and that the case might be one of psychogenic depression. A naïve metaphoric expression of her ideas of infection, together with an invaliding sense of sterility, go to make up in an inferior individual a picture for which there seems to be no very appropriate place in our present system of classification.

Feeble-Mindedness vs. Dementia Præcox.

Now and then it is difficult, in the absence of a satisfactory anamnesis, to differentiate defectiveness from a simple type of dementia præcox, though considerable stress is laid upon the Binet-Simon when failure scatters over several years, say from eight to twelve. We are usually loath to make a diagnosis of dementia præcox upon a defective basis. Though, no doubt, this occurs at times, the average præcox has not been intellectually defective whatever his other faults may have been, and the disturbed periods of the feeble-minded are more apt to be of a manic type than otherwise. Several cases of this type occur in this series.

For example, No. 66, a woman mentally aged about ten years, after treating her children badly following desertion of her husband, was deprived of them by court action and developed the idea that one of them had been kidnapped by two negroes. This idea was reacted to quite adequately and because of the trouble she made about the court she was finally committed. In the hospital she works well in the occupational therapy department, though it is said that she talks to herself at times. Here the question is that of deterioration in dementia præcox versus the development of a simple paranoic trend in a feeble-minded individual. Continued observation has rather strengthened the probability of the latter diagnosis.

The question as to whether or not there are individual types of reaction, very poor in quality but not necessarily dementia præcox-like in gravity, cannot well be answered unless the cases in argument have already died mentally intact or have developed a rather typical deterioration. The preliminary flurry in dementia præcox is easily recognized in retrospect but not so readily at the time. For example, Bleuler quotes the case of a young soldier who, when asked to present his gun for inspection, quite unexpectedly assumed a threatening attitude with the remark, "While I live I will

not disgrace my weapon." Not until six years later did the patient begin to manifest other symptoms of dementia præcox.

Case No. 2 illustrates this latter point rather well. A Russian Jewess gave a vague history of a brief attack of nervousness and fear at the age of twelve. When admitted at nineteen she was much elated following an extended period of physical complaint and depression. She was without hallucinosis and quite talkative though not showing a flight. The staff wavered between manic depressive and dementia præcox. One man held that she showed too much emotion to be a præcox—a not uncommon viewpoint, even among experienced men who seem to forget that loss of affect, though an important aid when present, is not at all a requisite for a diagnosis in the early stages. The patient was paroled, much improved, worked four months, suffered influenza and returned mentally excited, talking irrelevantly, hallucinating, filthy in habits and with little interest in her surroundings.

CONCURRENT MANIC AND SCHIZOPHRENIC REACTIONS.

Now and then paranoic or schizophrenic reactions occur in an individual who also manifests decided manic depressive tendencies.

Case No. 25 is a man of 30, a German Jew, heredity unknown, attained the fifth grade at thirteen, changed jobs frequently, never earned much money; four previous attacks, 1907-1913. He tried army life with poor success; was invalided home from France, and finally transferred from an army hospital with the diagnosis of dementia præcox. When received he showed a marked manic reaction, mood elevated, active, in good contact with his surroundings; but had many odd ideas; had heard God's voice; was the Christ; his mother was Mary, etc. When told there were others in the hospital who claimed to be Christ he responded manic-like that they were imposters who went insane when he was born because they knew him to be the real Christ. He had many peculiar sexual ideas and was very probably somewhat homosexual. He described in detail the visions wherein he discovered his true parentage and his mission as the Savior to the Israelites. Gradually he quieted down and was taken out by his mother, who states he has never been well, even between attacks. At present he is said to be in some government institution. The writer has had a touch-and-go acquaintance with the patient for many years in another hospital and had always thought of him as quite a typical manic until a wealth of schizophrenic delusional formation was revealed in this last examination.

CLOUDING AND CONFUSION.

In the description of some half-dozen cases, the patient is said to have appeared to be *confused* at one time or another and in a number of cases this account, together with some apparent degree

of amnesia, has led to a disagreement in diagnosis; that is, the condition has been assumed to be one of actual clouding of consciousness. Confusion is perhaps best reserved in case records for the description of states of uncertainty, such for instance, as may normally be found in the presence of emotional turmoil, and which may very well exist in acute præcox reactions as well as in states of depression with extreme agitation, etc.; thus reserving the term "clouding of consciousness" for such cases of a delirious or semi-delirious character as seem to be toxic or infective in character. In four cases of the series the term "confusion" was applied to describe the condition of a patient in whom other symptoms pointed very strongly to dementia præcox. One was probably an acute catatonic excitement, another became later an obvious præcox who betrayed in various ways an evident præcox mechanism although later he seemed to recover. Another patient appeared actually clouded and was probably of an infective exhaustive type; still another evidently suffered from alcoholic delirium, while one or two were senile. In a young individual betraying symptoms of confusion without toxic or infective history the chances would seem to be in favor of a schizophrenic mechanism, though the tendency upon the part of many staff men is to give the patient "the benefit of the doubt."

INADEQUATE TYPES OF REACTION.

A few cases represent types of reaction which, though poor in character and suggestive of dementia præcox, are not quite definite enough to bear this label, though too severe to be classified as psychoneuroses.

No. 10 was a colored woman of 47 with history of previous attack. At the time of the last attack her husband was in jail as a conscientious objector, when she began to look for the end of the world; at the Lord's direction refused to eat; heard other commanding voices, etc. Finally she accepted the suggestion that she offer herself as a sacrifice and cut her throat, following which she was committed. Upon admission she was quiet, heard no voices, seemed to have some insight into her abnormal experiences but was still very religious and fond of biblical quotations; in fact, said she had been overly religious for a number of years. She worked well and was discharged apparently recovered, three months after admission. An account of her case later received from New York state described a somewhat similar attack in 1907, involving a ten months hospital

residence and a diagnosis of hebephrenia, from which, however, it is interesting to note that she was discharged *recovered*. Here the staff agreed upon a descriptive diagnosis of compensatory religious ecstasy in a colored woman of poor makeup and subject to stress on account of her husband's imprisonment.

COLORED PATIENTS.

Six of our cases were colored and represent the uncertainty often felt in the presence of mental disorders in this race. Many are superstitious and have naïve religious beliefs, which together with thought processes of peculiar vividness, a childlike adaptation to hospital routine and close contact with environment, often lead to confusion in diagnosis, with a tendency to an overemphasis of supposedly manic depressive traits.

PRESENILE TYPES.

The diagnosis of *presenile* is offered by one staff member or another in the case of almost all patients over 40 and not obviously organic in type. Kraepelin reminds us that this field is perhaps the most obscure in all psychiatry. The writer is not well satisfied with its treatment in the classification recently adopted. By reason of its inclusion under the senile psychoses, too much in the way of organic dementia must be found or at least assumed to be present. Several cases in this series suggest the presenile type.

No. 41 was a woman of 58, with a bad heredity and a paranoid onset dating back a year and a half before admission, with an increasing amount of conduct disorder. Another state hospital where she stayed a few weeks reported that she laughed to herself, said she was Christ, denuded herself, seemed confused and was restless. After being cared for in some private institutions, she was finally admitted to the Chicago State Hospital, where she was described as being impulsive, lay in bed with the covers over her head, was inaccessible, etc. Blood pressure was 160-80. When paroled a few months later she was delusional and incoherent. Three weeks later she reported in person and one of our most experienced and conservative staff physicians noted her as being in "very good condition." Later she was discharged recovered. Unfortunately at this time when she would have talked freely there was no inquiry into possible dementia. Dementia *præcox*, arteriosclerosis and presenility were discussed at staff meeting. A report secured a few days ago states that she did the housework and marketing, was quiet and well behaved for six months and then committed suicide by hanging.

Case No. 61 is interesting in that it concerns a woman of 52 who suffered an attack in 1912 and was confined in a western hospital from which she was discharged as recovered after a year and three months, diagnosis manic depressive, no details. In April, 1919, she came to Chicago without friends or funds to find a missing daughter, was apprehended and committed on account of strange stories concerning vast estates in Europe, her work for foreign governments, etc. Blood pressure was 160.80; blood Wassermann negative. She was usually quiet and well behaved but had spells of irritability and talkativeness. Her ideas were rambling, of a grandiose trend and developed no further. General knowledge and memory seemed intact. Dementia præcox and presenility were considered. She continued delusional and was irritable at times but became a good worker, manifested some insight and was finally paroled after an institutional life of one year. In this case, was the patient's first attack really manic depressive in character, and did she actually recover in the interim? Is she now a manic depressive in the involutional period; or is she senile-presenile, and if so where, after eight years, is the dementia?

ORGANIC CASES.

Eight or ten cases were undiagnosed because of what were thought to be organic findings though of an indefinite or confusing character: matters of blood pressure, cerebral spinal fluid findings, sluggish pupils, hardened radials, etc. Only three were actually organic, two of these were already hemiplegic and the third is an interesting case of psychopathic constitutional inferiority—a man of 28 who presents a four-plus cerebral spinal fluid Wassermann with 172 cells, positive blood and negative Lange, no physical symptoms. He is at present out upon escape but is said to show no evidence of mental enfeeblement.

There are, of course, many other interesting cases that might be discussed from the standpoint of diagnosis but they are of no especial interest save to those who have personally observed them.

CONCLUSIONS.

1. The undiagnosed cases in institution psychiatry present interesting problems as to diagnosis and prognosis.
2. Many case histories are lacking in clear description of historical facts, conduct disorders, stream of speech, etc.
3. Undiagnosed cases should be followed up most carefully. The average hurried and perfunctory note is only a little better than no note at all.

4. Conclusions without a statement of facts are misleading. Terms such as *rambling*, *confused* and *violent* should be used very cautiously in the primary case record.

5. Undiagnosed cases should be represented as often as new facts discovered will warrant.

6. In a considerable percentage of undiagnosed cases, disagreement and hesitation upon the part of the staff indicate, though oftentimes unwittingly, a good prognosis.

7. Confusion and apprehension in an acute psychosis would seem to indicate dementia præcox more often than any other disorder.

8. The absence of definite hallucinosis in a case otherwise doubtful contributes to failure in classification.

9. There are depressions of psychogenic origin that are not manic-depressive in nature and these types often occur between the ages of 40 and 60 with recovery.

10. The senile-presenile state is uncertain ground. A return should be made to the Kraepelinian presenile grouping.

11. Psychiatry is so far from being an exact science that many cases must be left undiagnosed if the psychiatrist is to retain his self-respect. He cannot honestly diagnose them all.

ANALYSIS OF MORE THAN 200 CASES OF EPILEPSY TREATED WITH LUMINAL.

BY DR. C. C. KIRK,

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Epilepsy is always interesting in that the pathology of the disease is as yet unknown, and the manifestations are not always the same. Many object to the word epilepsy and prefer to speak of the epilepsies. Certainly convulsions occur in arteriosclerosis, hysteria, nephritis, certain forms of heart disease, many types of neuro-syphilis, multiple sclerosis, brain tumor, rabies, tetanus, alcoholism and strychnin poisoning, but these do not mean that they are genuine epilepsy. They are symptomatic of certain somatic changes. It really does not matter whether it is a disease entity or whether it is a syndrome, and it does not matter much whether it is spoken of as epilepsy or as the epilepsies. It is not the purpose of this paper to discuss the pathology or etiology of epilepsy. In our treatment of epilepsy we have not had under treatment any of the so-called symptomatic epilepsies, but we have had under treatment the idiopathic or essential epilepsies with the exception of one case of traumatic epilepsy.

Two thousand years ago Hippocrates recommended general hygienic measures in the treatment of the epilepsies. Perhaps our understanding and application of general hygienic measures are a little better than they were in the day of Hippocrates. Physicians who are familiar with the treatment of epilepsy always impress upon the patient and nurses the importance of diet. Indiscretion in diet probably produces more seizures than any other one thing. Next in importance is bowel elimination. Of course, other methods of elimination, occupation, fresh air, etc., are certainly necessary in the armamentarium in combating epilepsy.

Epilepsy is regarded as almost a hopeless condition. Craig Colony for Epileptics shows 92 patients recovered out of more than 5000 treated, and these 92 have only been clear of seizures for two years, and it is probable that a certain number of these 92 will eventually have a recurrence of their disease if they continue to live any length of time.¹ The 175,000 epileptics in the United States and their friends, besides the entire medical profession, have been grasping at straws in the way of treatment. Much damage has been done in the past as the result of fraudulent remedies that were advertised through the newspapers and other sources. They created a false hope in the mind of the epileptic, which eventually resulted in greater pessimism, less hope and a feeling of despair in the minds of those who have been striving for relief from this strange and mysterious malady. For many years the medical profession has depended almost entirely on bromides in the treatment of this disease, but relief from bromides is often incomplete, and the objections to their prolonged administration are so well known that I shall not undertake to discuss them in this paper. Many physicians reject their use entirely.

LUMINAL.

Actions and Uses.—It is claimed that the introduction of the phenyl group increases the hypnotic power of Luminal (phenobarbital) over that of barbital.

Luminal is said to produce sleep in the cat and dog with a satisfactory range between the effective and lethal doses, affording a deep, quiet sleep, without injury to the respiration or circulation. Very rarely a period of excitement preceded sleep.

It has a sedative action on respiration, lessening the frequency of breathing, although the volume of each respiration is increased. It kills by respiratory paralysis. It is eliminated by the kidneys, a certain portion being probably decomposed in the organism. No renal injuries or gastric disturbances have been observed.

Luminal is claimed to be a useful hypnotic in nervous insomnia and conditions of excitement of the nervous system.

Dosage.—From 0.2 to 0.3 gm. (3 to 5 grains) increased if necessary to 0.8 gm. (12 grains). A maximum dose of 0.8 gm.

¹ Annual report Craig Colony for Epileptics, January, 1920.

(12 grains) should not be exceeded. Smaller doses are sometimes efficient.

LUMINAL-SODIUM.

DOSAGE.—For hypodermic injection Luminal-sodium is used in the form of 20 per cent solution, prepared by dissolving the salt in boiled and cooled distilled water; 2 c. c. (30 minims) of the solution contain 0.4 gm. (6 grains) of Luminal-sodium. The dose of Luminal-sodium is ten per cent greater than that of Luminal.

Luminal-sodium may be given hypodermically in doses of 0.1 to 0.3 gm. ($1\frac{1}{2}$ to 5 grains).

The use of Luminal in the treatment of epilepsy in the United States was comparatively unknown until after the war. Luminal is a German product and was used by the Germans in the treatment of epilepsy in 1912. Grinker^{*} says that Luminal was prepared in 1911 and given to the medical profession in 1912-13 by the Germans. He states that he began the use of this drug at that time, but after the beginning of the war was unable to secure Luminal. Dercum made the first report of the use of Luminal in the treatment of epilepsy in the *Therapeutic Gazette* September 15, 1919. He states that his attention was first called to the use of Luminal in the treatment of epilepsy in July, 1914, by Dr. Richard Eager of the Devon County Asylum, Exminster, England. He claimed remarkable results even in the most confirmed epilepsies. He did not report any specific number of cases, but said the abolition of the convulsive seizures had not only extended over several months but even over several years, and that the efficacy of the drug proved most remarkable in the essential and what was formerly termed idiopathic epilepsy. He said that Luminal acted as a specific in certain cases.

The use of Luminal in the treatment of epilepsies in the Arkansas Hospital for Nervous Diseases was instituted with considerable skepticism and only with the hope of controlling the seizures and not with the expectation of a cure of the disease. On December 8, 1919, we selected as cases to be treated a certain number of patients whose seizures were the most frequent and the most severe, some of whom had been bed ridden for weeks, months and

^{*} Paper read before American Medical Association, New Orleans, May, 1920.

even years. We felt that if Luminal would improve the condition of these patients we would then be justified in proceeding in the treatment of milder cases. The results in certain cases were so startling and so remarkable that within thirty days all cases of idiopathic epilepsy were placed under treatment. Our method of treatment consisted of $1\frac{1}{2}$ grains of Luminal at bed time. Luminal was prepared in tablet form. After about sixty days our supply of Luminal was exhausted and it was necessary to use Luminal-sodium. The Luminal-sodium seemed to be as effective as the Luminal. At no time did we notice complaint on the part of the patient of being dizzy or heavy with this dosage. Within a few days we noticed a change in the number and severity of the seizures of the patients who were under treatment. We did not increase the dosage except in five instances. In these particular cases we used $1\frac{1}{2}$ grains of Luminal or Luminal-sodium night and morning, and in two instances we used it three times per day, but after the seizures were under control we then resumed our old method of $1\frac{1}{2}$ grains at bed time.

On May 1 our supply of Luminal and Luminal-sodium was exhausted with the exception of a small quantity which we reserved for the use of serial cases and cases of status epilepticus. Within a few days after our supply of Luminal was exhausted there was a very noticeable increase in the number and severity of seizures, but this was not equal to the conditions as they existed previous to the treatment and up to the present time, May 26, 1920. We cannot agree with one writer who claims that the seizures were more severe and more frequent than ever before.

All stimulants, tea, coffee, tobacco, were prohibited. No change in the diet was made except a closer supervision was made over the diet of the patients in regard to the quantity of food eaten. You are all familiar with the tendency of the epileptic to gormandize. We learned that many of our patients were secreting food in their clothing while in the dining room and eating it after going to their rooms. This particular feature caused us considerable trouble for a time after the treatment was begun. The bowels were kept open, as usual, with cathartics consisting very largely of epsom and Rochelle salts. The treatment of serial seizures and of status epilepticus was carried out in the usual way, that is to say by the use of elimination, restricted diet, but

instead of using drugs we formerly used to combat these conditions Luminal was substituted, but it became necessary to use larger doses, as many as five grains of Luminal every three hours were used.

Number of Convulsions.—There were 61 patients who had no convulsions since treatment was begun; 106 patients that had less than five convulsions while under treatment; 45 patients that had more than five convulsions. February 8 one patient died of lobar pneumonia; February 25 one patient died of mitral regurgitation; March 9 one patient died from status epilepticus.

The use of Luminal in the treatment of epileptic seizures is in the experimental stage and not until several thousand cases have been treated over a period of years will we be able to determine its true value.

Conclusions.—There was immediate decrease in the number of seizures, a decrease in the severity of the seizures, many of them changing from grand mal to petit mal, decrease in the severity of furore and a shortening of the time of confused states, an improvement of the mental and physical health of all patients, fewer number of accidents, a general improvement of the moral tone of the wards, and a complete cessation of the seizures in a large number of cases. No deleterious effects were observed on the kidneys or stomach; circulation, temperature and respiration are uninfluenced. It is not a habit producing drug and is not attended by any pleasurable or disagreeable sensation. In certain cases the drug is effective in twenty-four to forty-eight hours, in others not until a week or more has passed.

The purpose of this paper is to make a preliminary report on the effects of Luminal on institution cases, which are obviously the most severe types of epilepsy to be seen. The reports made by neurologists are apt to cover milder types of epilepsy which are treated in private practice. The results are so gratifying that I desire to present to the medical profession our results that they may see for themselves just what can be done with the severest types of epilepsy. Luminal gives promise of being the most effective and the least harmful of all drugs that have ever been used in the treatment of epilepsy, and will be a godsend to these poor, afflicted, pitiful, hopeless defectives.

CASE REPORTS.

CASE No. 1.—A. N. Age 24 years. Onset of seizures at the age of 4 years. Diagnosis, grand mal epilepsy with deterioration. Had been bed-ridden four months, having an average of 25 convulsions daily. Seizures were grand mal in type, very severe, at times throwing herself out of bed and injuring herself. December 8, 1919, $1\frac{1}{2}$ grains of Luminal was instituted to be given daily at bed time. December 9, 9 convulsions; December 10, 10 convulsions; December 11, 4 convulsions; December 12, 5 convulsions; December 13, 4 convulsions; December 14, 6 convulsions; December 15, 2 convulsions. There were no more convulsions until December 23, 1 convulsion; December 27, 2 convulsions; December 29, 2 convulsions; January 2, 3 convulsions; January 4, 1 convulsion; January 6, 1 convulsion. Her mental and physical condition at that time was very greatly improved. She was much heavier and up on ward. No more convulsions until January 26, 2 convulsions; January 31, 1 convulsion. No convulsions during February. March 11, 2 convulsions. On March 1 the supply of Luminal was exhausted and Luminal-sodium was given, the same dosage except an increase of ten per cent.

CASE No. 2.—M. D. Female. Age 14 years. Onset of seizures at the age of two years. Diagnosis, grand mal epilepsy plus imbecility. Was confined to her bed, having from two to 36 convulsions in 24 hours, untidy, had never learned to walk or talk. Treatment began December 17. December 18, three convulsions; December 31, three convulsions; January 1, two convulsions; January 4, three convulsions; February 1, one convulsion. Patient is now out of bed and on the ward, has gained in weight, has learned to walk and talk, and is attending the school for the feeble-minded. Has had one convulsion up to May 15.

CASE No. 3.—A. J. Female. Age 13 years. Confined to her bed, having convulsions ranging from five to 15 daily. Placed on Luminal, $1\frac{1}{2}$ grains daily, December 23. December 26, one convulsion. No seizures since that time. Patient able to be up on ward since January 1.

CASE No. 4.—L. B. Female. Age 15 years. Onset at the age of two years. Diagnosis, grand mal epilepsy plus idiocy. Was having five to 12 convulsions weekly; bed-ridden because of the numerous injuries incurred before being placed in bed, nose having been broken on several occasions and other bruises on the face and body. Placed on treatment December 21. December 22, four convulsions; December 27, two convulsions; December 31, one convulsion. No convulsions since. Up on ward. Better condition physically.

CASE No. 5.—M. G. Female. Age 17 years. Onset at the age of ten years. Diagnosis, grand mal epilepsy in a moron. Was having an average of 14 convulsions weekly. Had very severe convulsions, falling on her face and frequently bruising herself; nose had been broken on one occasion. Treatment was instituted January 8. January 12, one convulsion; January 27, one convulsion; March 15, two convulsions. No further convulsions.

CASE No. 6.—D. S. Female. Age 27 years. Onset at the age of ten years. Diagnosis, epilepsy plus imbecility. Was having six convulsions monthly. Treatment instituted January 8. March 4, one convulsion.

CASE No. 7.—G. E. Female. Age 17 years. Onset at the age of eight years. Diagnosis, grand mal epilepsy plus imbecility. Was having an average of one to six convulsions daily. Treatment instituted December 15. December 30, one convulsion; January 7, two convulsions; January 18, one convulsion; January 21, one convulsion; January 27, one convulsion; March 5, one convulsion.

CASE No. 8.—S. S. Female. Age 14 years. Onset at the age of three years. Diagnosis, grand mal epilepsy in a moron. Was having ten convulsions weekly. Treatment began January 8. February 1, one convulsion; February 6, one convulsion; March 2, one convulsion.

CASE No. 9.—R. P. Male. Age 46 years. Patient began having petit mal attacks at the age of 17, and later developed grand mal seizures. These attacks were followed by confused states lasting several hours, sometimes 24 hours. Was placed on Luminal January 4. Has had no convulsions or confused states since that date.

CASE No. 10.—H. K. R. Male. Age 30 years. Began having petit mal attacks at the age of two years and has been having on an average of two or three petit mal attacks weekly. Was placed on $1\frac{1}{2}$ grains Luminal at bed time January 4. Has had no convulsions since that date.

CASE No. 11.—C. M. Male. Age 59 years. Onset at the age of five years. Diagnosis, grand mal epilepsy plus moron. Has been having on an average of two to three grand mal convulsions weekly. Treatment was instituted January 4. No convulsions since that date.

CASE No. 12.—P. O. Male. Age 12 years. Began having seizures at the age of ten years, grand and petit mal attacks. Was having from one to five convulsions weekly; occasionally would have five to ten seizures within a day or two followed by a remission of two or three weeks. Treatment was instituted January 7. Has had no attacks since that date.

CASE No. 13.—E. S. Male. Age 11 years. Onset at the age of three years. Diagnosis, grand mal epilepsy plus infantile cerebral palsy. Was having two or three hard grand mal attacks daily over a period of three or four weeks followed by a remission of two to three weeks. Treatment instituted January 7. No convulsions since that date.

CASE No. 14.—G. C. Male. Age 29 years. Colored. Has had grand mal seizures for 15 years, averaging one seizure daily. Treatment instituted January 10. No seizures since that date.

CASE No. 15.—H. B. Male. Colored. Age 16 years. Onset of seizures early childhood. Diagnosis, grand mal epilepsy plus imbecility. Has been having on an average of two to three convulsions weekly. Treatment instituted January 10. No convulsions since that date.

DISCUSSION.

DR. L. M. JONES.—I would ask the speaker if the treatment has been continuous. Do you continue the drug after beginning it? Are you still giving the drug; what is the average dosage, and do you average more than one dose?

DR. H. W. MITCHELL.—Following several favorable reports upon the use of luminal we decided to use the drug as advised in a series of chronic, insane epileptics, many of whom were for short periods among the most disturbed and troublesome patients in the hospital. We approached the problem with a good deal of skepticism as to the outcome and certainly had no expectations of curing chronic epilepsy. Dr. Darling, of the hospital staff, has prepared a short report of results of this medication upon a series of 15 patients under his care and has charted his results.

The number of convulsions for a four months period before the use of the drug showed an average of eight convulsions daily. Following the use of luminal, as generally advised, the convulsions of the same patients were reduced to an average of 1.4 daily during the time luminal and sodium bromide were used jointly. After two successive months of treatment under the influence of luminal alone, convulsions did not rise above 3.6 daily. Removal of the drug for one month showed an immediate increase in the number of convulsions.

The most noticeable effect upon the patients under observation was the improvement in their daily reactions to ward life. There was much less irritability and consequent quarrels, a great reduction in the minor injuries sustained during seizures and no exhibition of the periods of clouded consciousness which the same patients had manifested frequently before the use of the drug. The attacks were less severe when they did occur.

So far as could be detected by careful observation there were no noticeable bad effects from the use of the drug. Our limited observation would seem to indicate that the condition of chronic epileptics might be made much more comfortable by the use of this new remedy. We have had no experience with the use of the drug in patients who are developing epilepsy and therefore can give no opinion as to its curative value in the early stages of epileptic conditions.

DR. SWINT.—Our attention was called to luminal in the treatment of epilepsy by the reports of Drs. Dercum and Sands. At the Georgia State Sanitarium several weeks ago we selected 10 white males and 10 white female epileptics to try out this remedy. We selected these cases with the idea of getting some that had convulsions often and some that did not. We ran charts on these cases several days before treatment was begun in order to determine how often the convulsions would occur without treatment and with treatment. We gave our cases $\frac{3}{4}$ -grain luminal three times a day and it lessened the number of convulsions in most of our cases and seemed to control it in some. Most of our female patients were rather drowsy and

did not seem to have the usual interest in things, they were inclined to be sleepy. In one case it seemed to make the convulsions worse or the patient had them oftener. We are of the opinion that while luminal may control the convulsions in epilepsy, it is not curative. Of course, our experience is limited and we are not in a position to offer any definite opinion as to the value of the drug in the treatment of epilepsy. I was very much interested in Dr. Kirk's paper and the results in his cases.

DR. CHAS. E. ROSS.—I have been using luminal since 1915. I had a patient go to Chicago, and he was put on luminal. We watched him quite a while; I do not just remember how many seizures this man had, but I know to-day this man is absolutely free from seizures, is taking care of business and has made a success. I got some of the drug and have used it continuously since, and this is my experience: in cases of grand-mal where they have two or three seizures a month with usually no psychosis, that luminal sodium acted better than a straight luminal, and in most cases controlled the seizures. Luminal sodium in one grain dose at bed-time acts well. In some cases I think it does seem to retard the patients who only have a few seizures a month; it seems to stupefy them; it retards them mentally in some cases. They tell me they do not like to take the drug because they do not seem to have the same mental ability to perform their work as they did before taking the drug, but whether that could be overcome or not I do not know. I do not have a chance to follow up cases like you would in an institution. I have cases referred to me, and I ask them to write me as to what their condition is and how they progress; once in a while they will do this, and sometimes I will not see a case for a year.

I am glad to have heard this paper. I believe that in your institutions for the treatment of epilepsy, where you have a psychosis with the epilepsy, luminal will do more good than it does in private practice where you are dealing with an epilepsy without a psychosis, or when your patient only has from two to four seizures a month.

DR. KIRK.—I should say that we had used the same dose, one and one-half grains; you do not have to give it in large doses. If we were obliged to narcotize the patient then we might think of other drugs that would produce the same results. We gave our patients luminal every night; there were no intervals in which we missed the use of the drug. Luminal is probably like many other drugs, there will be certain individuals who will not respond to the treatment. There are people in the south who are not cured by quinine, which is regarded as a specific for malaria; some people are poisoned by certain drugs. Perhaps there will be cases of epilepsy that will not respond, or they may be poisoned by this drug. Therefore we will not be able to reach definite conclusions until we have treated thousands of cases. We are not trying to delude any person into believing that luminal is a drug that will make over individuals into normal persons when they are constitutionally weak.

The idea that we are not progressing in psychiatry and in nervous and mental diseases does not appeal to me. I believe we *are* progressing.

16 years ago when I went into this work we were working under a classification that was not practical; I did not know one disease from another; I had been in the hospital one year and could not classify my patients. When Kraepelin's classification came out many of the superintendents in the state refused to accept it, and it was several years before certain superintendents accepted it; they were reactionary; there was no interest in it. So to-day when we talk about the cure or the relief of epilepsy there are many men in this auditorium this morning who will go away feeling that luminal is a fad and will be here but a few weeks and pass away just as other drugs that have been used. I would like to see the older men in this specialty encourage the young men who are coming into this work because you know we do not get very many able young men to take up this work. In the first place they do not get enough money. When one tries to secure the services of an assistant physician does he get the ablest recent graduates? No. They are going into something that is more interesting and more remunerative. I have been listening to the discussions and there are many reactionary ideas that I have been impressed with. I feel that the younger men who are working in institutions should have greater support and more encouragement and when they feel interested enough to make investigation along any line we should not discourage them; let them go ahead and if they can do anything for these unfortunate people, help them do it.

THE STATE PSYCHOPATHIC HOSPITAL.

By ALBERT M. BARRETT,

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In spite of the general interest that has been shown in the subject of psychopathic hospitals by those who are concerned with the care of the mentally disordered, the establishment of this type of institution has progressed but slowly.

The experiences of the few hospitals of this type that are already in existence have definitely shown that they have a field of work in which they are accomplishing great good, and that they have developed machinery for meeting aspects of mental disorders in ways not otherwise provided.

Discussions that have centered about the establishment of these hospitals have brought out some differences of opinion as to the type of organization that was desirable and the field of work with which they were to be concerned. In a large measure these differences have had their source in the feelings of necessity to adapt the new organization to local situations, this seeming to be the most practical way to bring about public support. It has, however, usually been appreciated that compromises were being made with the conception of the ideal institution. Thus, there are now in existence psychopathic hospitals, state psychopathic hospitals, psychopathic wards of general hospitals, psychiatric clinics and psychiatric institutes.

All of these have their distinct values and are meeting their problems in a more or less adequate manner, but the idea must be kept clearly in mind that they are not all equivalent.

The psychopathic hospital, whatever be its title, implies an institution of a definite type of organization and special facilities. As formulated by Dr. Southard in one of his reports "it is an institution ready to attack within its means all the problems of psychopathology, both practical and theoretical, having in mind the patient of the day and the patient of the future."

A conception such as this can only be realized by an organization having its own special building for the observation and treatment of a limited number of patients. It must be administered by a medical staff of adequate size, specially qualified for psychiatric work. It should have ample laboratory facilities for research and clinical diagnosis and above all its activities should be dominated by an attitude of keen scientific interest.

Different problems of situation will in a general way determine two types of psychopathic hospitals. One that must adapt itself to the problems of mental disorders as they concern the state as a whole or the state psychopathic hospital, and one that must adapt itself to the psychiatric problems of a concentrated district or the municipal psychopathic hospital.

The circumstance that the care of the mentally disordered has always been a problem largely assumed by the state has naturally directed most interest to the state type of hospital. But, the field of work that will serve the purposes of the state as a whole will not meet the psychiatric problems that exist in every densely populated community. The density of population with its complicated social situations, the character of problems that are presented to organizations doing welfare work, those that arise in the schools, and especially in the courts dealing with crime and delinquencies, these and many other problems that have become apparent in larger cities during recent years require a special type of institution to adequately carry on the functions of a municipal psychopathic hospital.

It is our purpose on this occasion to discuss the organization and activities of the type of institution, that in our opinion would best serve the needs of the state as a whole, adapting its field of work to the existing organizations of the state that are now caring for the insane and mentally disordered.

At the present time perhaps the most urgent motive for the development of psychopathic hospitals is to serve as teaching centers for psychiatric training. This bears directly on the problem of the location of the hospital. Psychiatric teaching can be best carried on in as intimate connection with a medical school as possible. Where the state has a state university and in connection with this a medical school, this obviously should determine

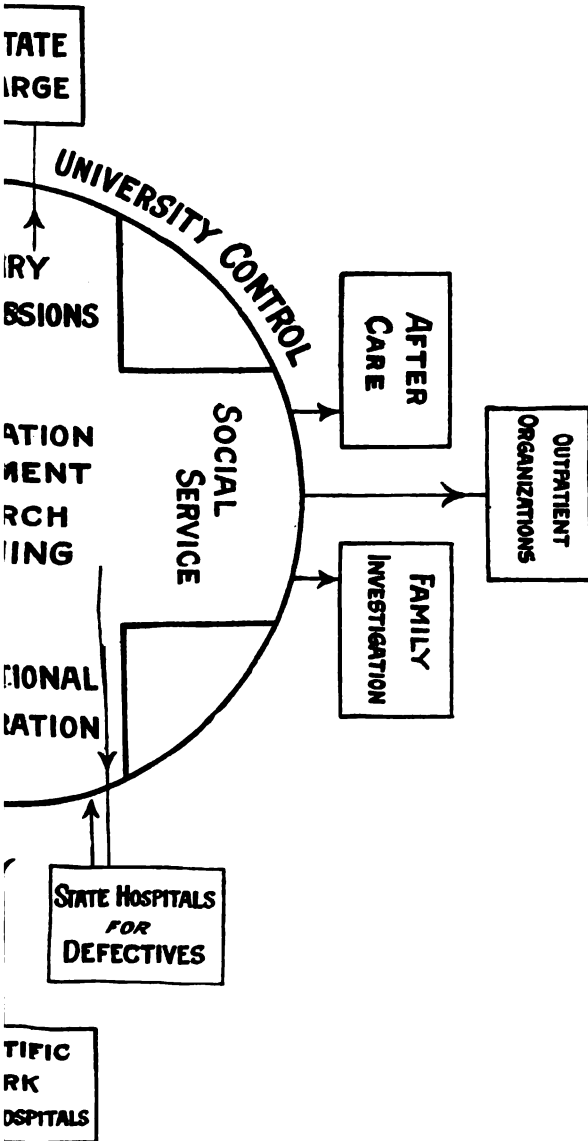
its location. While psychiatry should always be regarded as a branch of medicine there are aspects to the subject that may be taught with much success in connection with undergraduate courses of a university. Where the state university has no medical school a psychiatric hospital would still find a most useful place in close relation to the university. Where there is no state university its location might be determined by the size of a community, proximity to general hospitals, or district hospitals for mental disorders, or by special facilities peculiar to state situations.

The administrative control would in a large measure depend upon the system followed by a state in the administration of its district hospitals for mental disorders. The management might equally well be cared for by central boards of administration or by boards of trustees. Where the psychopathic hospital is in intimate relation with a university there is much advantage in having the governing board of the university or medical school represented on the administrative board of the hospital. Such an arrangement as this works most satisfactorily in the administration of the State Psychopathic Hospital at the University of Michigan. This hospital is under the control of a board of eight trustees, four of whom are chosen from among the trustees of the state hospitals for the insane and four from the board of regents of the university. By this joint administration the interests of the hospital both in its relation to university teaching and to the state organization caring for the mentally disordered may receive careful consideration.

In the plate accompanying this paper (Fig. 1) I have represented in diagram the organization of a state psychopathic hospital, its relations to the care of patients, and its field of work.

For purposes of discussion the fundamental activities of the hospital are sub-divided among (1) observation, (2) treatment, (3) research, (4) teaching. All of these intimately interlock and all center in the patient. While local circumstances, such as special relations with courts and welfare organizations, relations to general hospitals and medical schools, special types of clinical material, special laboratory opportunities, or a personnel unusually qualified for special problems may stress more particularly one of these fundamental divisions of the hospital's interests, it is

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our personal belief that the state will be rendered best service when these interests are balanced as equally as possible.

One advantage that the psychopathic hospital should have, that cannot well be a feature of a district hospital of a state is a degree of flexibility of operation that will allow it to take up special psychiatric problems that may arise at any moment. New avenues for extension of the interest of the hospital will be continually opening up, and the hospital should be ready and easily adjustable to meet any of these.

For carrying on these fundamental activities, the hospital should be provided with all necessary facilities: Its laboratories, treatment facilities, teaching rooms, apparatus and libraries should be adequately equipped and maintained. Unless this is done the hospital will lack the distinctive features that are one of the chief reasons for its establishment.

The essential purposes of a special hospital for intensive observation and treatment must necessarily limit its capacity. The exact number of beds that the hospital should have is a matter of detail, but the number should be small enough to permit a thorough observation and intensive study of its patients. Its size should be determined by the number of physicians it is practical to maintain on its staff. It is not practical to adjust its size to the demands for admission of patients. These, if the hospital attains success and holds the confidence of the people, will far exceed the ability of a hospital of moderate capacity to care for. It should be sufficiently large to furnish varied clinical material for teaching and to maintain the clinical interests of the staff. According to the size of budget that a state might allow for maintaining a medical staff its capacity should not be less than fifty beds nor should it much exceed one hundred. The State Psychopathic Hospital at the University of Michigan with a clinical staff of four full time physicians has a capacity of sixty-two beds in which are annually treated about three hundred twenty-five patients. The smaller the number of beds and the larger the clinical staff, the more do the patients benefit and the more opportunity will be available for research.

The psychopathic hospital is essentially a diagnostic hospital. It should be a hospital in which every facility of proven value.

should be available for diagnostic aid. As a treatment hospital its functions must unfortunately be limited owing to the prolonged course that is usual in severe mental disorders. The length of time required for cure or marked improvement of the psychoses is a matter usually of months and even years. To assume a prolonged treatment of patients and at the same time have space available to receive all patients that are specifically suitable for a hospital of this type would require a number of beds so large that it would be difficult to manage without a clinical staff of impractical size. Of the patients at Ann Arbor who recover under treatment in the hospital 84 per cent recover within three months and 69 per cent of all patients discharged have been in the hospital less than three months.

The limited capacity and special purposes of a psychopathic hospital demand that some selection should be exercised in the type of mental disorders that are to be admitted for examination and treatment.

While the hospital might be of great service to the state if it might act as a clearing house to which all mentally disordered patients who require treatment should be sent for examination, such a plan seems impractical owing to difficulties of transportation and the large number of patients that would require care. There are certain types of mental disorders that the psychopathic hospital is peculiarly suited to care for, and for which the state now makes inadequate provision. These are individuals who are mentally ill, but not to a degree or character to enter the district hospitals of the state. The larger number of such patients are ill with psychoneuroses or are suffering from pathological mental difficulties which interfere with their success in life, but do not require the legal restrictions that commitment to a hospital for the insane necessitates. Such patients come to the attention of physicians, school officers, social workers, general hospitals and from families who appreciate their mental illness, but hesitate in sending the patient to a hospital for the insane.

There are some special types of definite insane conditions that the psychopathic hospital should receive for diagnosis and treatment. These are patients with mental disorders directly interrelated with physical disease. Disorders such as these require

unusual skill and facilities for diagnosis. Their treatment is so largely medical or surgical that they should have the advantages of the special facilities available where a hospital is intimately a part of a general hospital or medical school.

In practice it has been found difficult to limit the admissions to any particular class of patients. Being a state hospital offering unusual facilities for examination and treatment, it is but natural that there should be a large demand by citizens of the state for the admission of those in whom they are personally interested no matter how unsuitable they may be for treatment in this special type of hospital. As the committing authorities become familiar with the purposes of the hospital this difficulty will be minimized. There are also advantages in having available a wide range of types of mental disorders for purposes of research and teaching.

The problem of types of patients that are to be admitted will in a large measure be determined by the points of contact that the hospital establishes with organizations of the state that come into direct relation with individuals with mental difficulties. As a diagnostic hospital it should as far as possible co-operate intimately with schools, courts, state institutions and welfare organizations of the state. It should be possible for these agencies to send to the psychopathic hospital for diagnosis individuals who seem to have mental disorders that may be related to their backwardness and delinquency or social maladjustment. The results of this observation should aid in a proper medical or social treatment.

The legal provisions governing the admission of patients to the hospital should be as free as possible from formalities that may in any way produce social embarrassment for the patient. While undoubtedly legal restraint of some sort is necessary for those who need treatment and yet are unwilling to enter the hospital or for those who may be a social menace if at large, the aim should be to arrange the conditions for admission so that they may approach as nearly as possible to those in practice for the admission of patients to general hospitals. During the past year 53 per cent of the admissions to the State Psychopathic Hospital at the University of Michigan were voluntary and of these 43 per cent were supported at public expense.

An important field of work for the State Psychopathic Hospital should be in connection with criminal and juvenile courts. In this they would be of great service in the determination of mental disorders in those accused of crime or delinquency. The extent to which a psychiatric hospital can extend its service into the field of criminology is at present much hampered by formalities and limitations that surround the administration of the criminal law. There is no more rational approach to the problems that concern the criminal courts than by study of the personality of the individuals they deal with. The needed information can only be obtained by the psychiatric examination. While there are serious difficulties in caring for criminal cases among the general group of patients of a psychopathic hospital, this need not prevent the institution from in some way developing a close co-operation with the courts.

The highly qualified personnel of the medical staff of the psychopathic hospital and its laboratory facilities should place the psychopathic hospital in the position of a state institute for psychiatry. As such it should have an intimate co-operation with the district state hospitals caring for patients with mental disorders; not only for the insane, but those for the epileptic and defective. It should be possible for these hospitals to transfer to the state psychopathic hospital such patients as may be expected to benefit by the diagnostic and treatment facilities of that hospital. This co-operation will be needed by reason of the necessity of transferring patients from the psychopathic hospital to these hospitals after a period of observation and treatment. The double interest thus established in the patient would be a helpful means of maintaining this co-operation. About 22 per cent of the patients discharged from the State Psychopathic Hospital at the University of Michigan are transferred directly to a district state hospital and an additional small per cent enter these hospitals after a period at home.

As a central institute co-operating with other state hospitals there are possibilities of conducting research activities in a most favorable way. In the work of the pathological laboratories, material for study could be furnished by the state hospitals and the results of this should be systematically communicated to the respective state hospitals. Such a plan will keep the medical

interests of all hospitals at a high standard. Its central relation to the state hospitals caring for the mentally disordered would provide the state with a most useful organization for determining policies dealing with mental disorders and of conducting a unified attack upon these serious problems as they affect the public health.

The laboratories of the hospital could assume diagnostic work not possible in the separate district hospitals. By doing the serological work for these state hospitals it could most effectively unite the interests of all in problems as they affect the state as a whole.

The facilities of the psychopathic hospital should at all times be at the disposal of the state hospitals for mental disorders. For purposes of study classes for systematic instruction in psychiatry should be arranged for the benefit of the medical assistants of the state hospitals.

This centralizing of laboratory functions need not interfere with the independence of action of the large state hospitals, nor should it limit the field of interests of these institutions. This has not occurred in Michigan where the psychopathic hospital has at all times had the most cordial co-operation from the other state hospitals.

A most important division of the activities of a psychopathic hospital is one that should be concerned with the social aspects of psychiatric problems. Mental disorders are so frequently interlocked with personal situations of environment, of family and occupational relationships, that the hospital will fall short of its possibilities for the treatment of patients unless it is prepared to deal with these problems.

These include both intra-and extramural interests. The intramural social psychiatric work involves studying the social relations of the patient in respect to family, school and occupational life. Unless this information is available, it is not possible to give adequate treatment to a large proportion of patients seeking aid from the hospital. In this feature of the work of the hospital it is desirable that there be an intimate co-operation between the medical staff and those who are technically trained in psychiatric social work. While the attitude of the hospital towards the patient should always be dominated and directed by a medical point of view, there are some aspects of treatment that can be

well cared for by lay workers who are specially trained in the problems of social influences upon personality. If this is recognized by the hospital and adequately provided for the clinical work will be greatly facilitated.

The interdependence of social relations with problems of mental health forces upon the hospital the necessity of assuming extramural responsibilities. As a state hospital having the entire state as its field of work the possibilities for extramural work and social psychiatric service are almost unlimited. The fundamental purpose in the organization of this work should be to extend as far as possible facilities for psychiatric diagnosis and treatment to the citizens of the state. In details and plans of operation this extramural work must be somewhat different from those of the psychopathic hospital of a municipality. This is largely due to the widely scattered and often far distant localities from which patients come to the hospital and to the lack of development of social welfare organizations in the smaller communities.

The hospital should maintain out-patient clinics, traveling field services and should carry on family investigations that concern the patients they examine and treat. The development of the extramural work at the State Psychopathic Hospital of the University of Michigan has been one of its most useful features. In its local out-patient service in connection with the general hospital of the university it annually examines over 600 patients and in its out-patient service in Detroit over 1200 patients are annually cared for. Plans for future developments include the organization of a traveling psychiatric clinical service that will enable the hospital to extend its facilities to most of the towns and communities of the state.

Not only should the state psychopathic hospital be interested in what directly bears on the treatment of its patients, but its position and facilities should make it the leader in the state in the field of mental hygiene and a force for educating the public regarding whatever is active in impairing the mental health of the citizens of the state. It should be the psychiatric division of the public health agencies of the state.

The conception of the organization and function of the state psychopathic hospital that we have developed in this discussion is something more than that of a hospital for treatment, research

and teaching in their more restricted meaning. It is that of a state agency to deal with psychiatric problems in their widest relations to the health of the citizens of the state. Its possibilities for practical services will only be limited by the ability of its administrative personnel and the financial support given to it by the state. It is a new unit of the states system for caring for the mentally disordered, supplementing the functions of the present state hospitals for the insane and able to coordinate all of the psychiatric activities of the state.

It is to be hoped that there may be a more general recognition of the need of such institutions throughout the country.

DISCUSSION.

DR. C. B. BURR.—There is a fine great big word down in the bottom of that circle—"cooperation." Those of us who had the pleasure of visiting Dr. Crile's clinic Wednesday morning saw an example of cooperation which put us all in good humor and made us feel that something effective was being done in that clinic. No hand was in the way of any other; there were just enough and it was beautiful—the art of it. Every individual around the operating table acted as if he or she had the undivided responsibility of the case.

I think cooperation has been illustrated very well in Michigan. Good work—that means service. This is a word we often hear and at times discount knowing the facts, but we certainly have it in Michigan. The psychiatric organization as carried on represents genuine cooperation.

DR. RICHARD DEWEY.—I want to say I am exceedingly glad to hear this subject brought before the association and in such an admirable manner by one who has been a pioneer in the correlation of the ideas governing the psychopathic hospital. I would like to ask Dr. Barrett something in reference to one point which brings up a good deal of difficulty at times—the question of commitment and detention of patients. I have given a good deal of thought to that subject and at one time when I read a paper before the American Neurological Association, the question was raised whether it should not be *discharge* instead of commitment, that should be controlled by the law. We all know that seven out of ten of the patients who come into the psychopathic hospital have no need of any legal form of commitment whatever, although the legal form is required by law, superfluous as it generally is, and a patient cannot get in there unless he has been legally and publicly declared insane, which is often a quite unnecessary proceeding. That fact is a great stumbling block; it undoubtedly is the cause throughout the land of hundreds of cases becoming chronic every year, from the fact that treatment is delayed and they will not submit to appear in court and be recorded publicly as insane; or those interested

in them will not permit it. The voluntary commitment relieves that difficulty to a certain extent, but not wholly by any means, and I am of the opinion that if arrangements could be made whereby the *exit* instead of the *entrance* was made the occasion of legal interference with the patient, a great boon would be conferred upon the unfortunate patient and his family. If the court which has control, keeps the record of all who are admitted, it would need only to inform itself as to those who *go out* in order that the main difficulty might be obviated. Suitable machinery could be put in operation to this end. The only trouble that need arise would be about discharging patients who are dangerous to themselves or others. The conditions of *leaving* the institution are the ones that require attention. Their admission might be voluntary, subject only to medical oversight, but such as are in need of supervision from being dangerous should be under medical and *legal control* and their *release* left to the court. If the medical officer should advise the court in regard to all such cases, judicial inquiry would *then* be in order and need only then be necessary.

DR. BRUSH.—Some years ago when I was at Utica, a man whose name I do not remember came up to the hospital and said "I want to get in, I am crazy." He lived some 75 miles from the hospital and we had to send him back to his own town to go through the machinery of being committed to the hospital. That made me think of voluntary commitments. For the last 28 years I have encouraged the voluntary application of patients for admission. Until the year before last 80% of our patients at Sheppard & Enoch Pratt Hospital came in voluntarily. We found no difficulty whatever. A few cases have had to be legally committed; a few cases have been removed by their friends, but very few. In regard to what Dr. Burr said about service, Dr. Barrett has shown us what that means and all of our psychiatric clinics in the United States have shown the same thing. Our state hospitals are doing the same thing—hard service. The psychiatric clinics are somewhat new in this country, but the spirit that has actuated them is quite different from that which actuates these clinics on the other side of the ocean. I had occasion some time ago to see some of the clinics in Germany, which had been, and which have since been held up to us as examples. Patients were brought to them from the courts; patients were held in order to study them, and patients were sent from other hospitals; there was constant interchange. My personal recollection is that nothing was done to follow up those cases; nothing was done to reach the community in which those patients lived; nothing was done in the matter of mental hygiene and nothing was being done in the way of service such as we see now. I think in that respect we have gone beyond what the notable clinics on the other side were doing.

DR. KIRK.—One of the arguments I have heard against the psychopathic hospital is that it prevents the study of interesting cases by the superintendent and assistant physicians. The answer to that question in my opinion is: the psychopathic hospital benefits the sick man and that is the one

question that needs to be answered. It has the facilities for making more accurate diagnoses and can give better and more thorough treatment. The psychopathic hospital is not interested in making a "hit," so to speak, with a board of control; it has more interest in the manner in which the sick are being cared for and not how much corn is being raised, nor how much money is being saved, nor how much the per capita rate is being lowered. I have seen boards of control go into a hospital and the first thing they did was to go out and see the farm and fine stock; many never go in to see the sick men in the wards. The superintendent who does not possess medical leadership will sooner or later, under the influence of these business boards, drift away from his medical duties and become more interested in the farm, stock and other business interests than he is in his patients, and this lack of interest will surely be reflected by his assistant physicians who in turn will show less interest in the medical work. I sincerely hope to see the day when all great states will have a psychopathic hospital with a scientific, progressive, aggressive medical leader, who will have no organization, administrative, or political problems to divert his mind from the overwhelming complex medical problems.

DR. COPP.—I hope we shall not carry away the idea that the psychopathic hospital is something separate and apart from our state hospitals in spirit and aspiration. The assistant physician should not lose his interest where a psychopathic hospital is established; it should increase and stimulate his interest and effort. That is what the psychopathic hospital should mean always; it should bring to him something that will help him. The same spirit and the same idea should permeate every hospital, large or small; they should strive to reach the same ideal. We are never at a stage of progress when there is nothing ahead. The psychopathic hospital is the next step in advance.

DR. OSTRANDER.—I do not think conditions such as described by Dr. Kirk exist in our state. The psychopathic hospital in Michigan not only stimulates the superintendent, but all the members of the staff, in doing better work in caring for the insane. There is nothing we have appreciated more in our state than the institution where Dr. Barrett runs things. There is nothing done that stimulates interest more than the psychopathic hospital. There is nothing we appreciate more than an opportunity to send our assistants, as we are allowed to do by the state, to the psychopathic hospital, and Dr. Barrett asks us to send them to his institution for a few weeks or months for instruction in psychiatry. The institution with which I am connected has advanced since we have been doing this and we are doing better work; all our institutions are doing better work; the work is better correlated between the institutions. Dr. Barrett has quarterly conferences with the medical superintendents, where matters of common interest are discussed. These conferences are exceedingly helpful.

DR. KILBOURNE.—I rise for a little information: what proportion in Michigan, of the total admissions for the year pass through the psychopathic

hospital? I would also like to know if this psychopathic hospital is more of an institution for teaching psychiatry than it is for the treatment of patients? I know it has a great reputation as a school of psychiatry. Do all voluntary admissions go into the psychopathic hospital, or, are commitments made to it? There is one objection to a hospital that takes in the whole state, and that is the distance to be traveled to reach it.

DR. BARRETT.—In reply to Dr. Dewey's remarks about laws of commitment, I think most of us appreciate serious disadvantages in the present laws governing commitment to state hospitals. It would be highly desirable if patients might enter these hospitals with no more embarrassment than attends the admission of a patient to a general hospital. This matter involves legal complications that it would be quite difficult to change. It would be a good plan if some organization might consider this matter and ascertain what could be done to secure more liberal provisions for commitments to hospitals for mental disorders.

Already we have made marked improvements over our past conditions. For a number of years it was possible in Michigan to admit patients voluntarily to state hospitals provided they would be maintained at private expense. Now there are legal provisions that make it possible for the hospitals to admit voluntary patients at public expense. The only legal formality required is that the patient should bring a statement that this was approved by the judge of probate. Such patients are free to leave the hospital on reasonable notice.

In reply to Dr. Kilbourne's remarks regarding the medical activities of the hospital, I believe that a state psychopathic hospital will be of greatest usefulness to the state when the functions of diagnosis, research, teaching and treatment are as equally balanced as possible in the hospital's interest. No one of these should be unduly emphasized at the expense of the others. The main object of interest should be the treatment of the patient. To this research and teaching are but adjunct functions.

REPORT OF THE COMMITTEE ON WAR WORK

To the Members of the American Medico-Psychological Association:

At the Seventy-third Annual Meeting of the American Medico-Psychological Association, held in New York City, May 29-June 1, 1917, a Committee on War Work was appointed to cooperate with the War Work Committee of The National Committee for Mental Hygiene. The National Committee for Mental Hygiene had, immediately upon the entrance of the United States into the World War, appointed a special committee to assist the Surgeons General of the United States Army and Navy in organizing to meet those problems in the field of nervous and mental disease that the experience of the Allied Armies had shown were sure to arise in the formation of the American Army and the participation of that army in battle.

Throughout the period of the war, the Association cooperated closely with the War Work Committee of The National Committee for Mental Hygiene in the preparation of plans for hospitals, in the selection of personnel—commissioned, nursing, and attendant—both through its special committee and its individual members, many of whom were members of the former committee.

At the close of the war it seemed desirable that a record be made of the work performed by the members of the Association, and, that the data for such a record might be obtained, a questionnaire was sent to each member. The following report is compiled from these data. It shows that 397 members of the Association served in one official capacity or another, the largest number serving as medical officers in the Medical Corps of the United States Army. The statistical record is as follows:

U. S. Army	261
Lieutenants	44
Captains	102
Majors	74
Lt. Colonels	13
Colonels	5
Contract Surgeons	23
Service in A. E. F.	98

U. S. Navy	10
Lieutenant (j. g.)	1
Lieutenants	8
Lt. Commander	1
Sea duty	6
U. S. Marine Corps	1
Lieutenant	1
Canadian Army	10
Captains	5
Majors	3
Lt. Colonels	2
British Army	1
Lieutenant	1
American Red Cross, foreign service, without other service in army or navy	3
Draft Boards, Advisory Boards, Volunteer Committees, etc., without other service in army or navy	108
U. S. Public Health Service	2
P. A. Surgeon	1
Surgeon	1
Special Service (foreign hospitals, etc.)	1

In presenting this report the members of the committee desire to express their appreciation to Miss Emily L. Martin of the office of The National Committee for Mental Hygiene for her interest and careful checking of all data that they might be as accurate as possible.

Respectfully submitted,

H. W. MITCHELL, *Chairman*

C. B. BURR

GEORGE M. KLINE

WILLIAM L. RUSSELL

EDITH R. SPAULDING

WILLIAM A. WHITE

FRANKWOOD E. WILLIAMS

MEMBERSHIP WAR RECORD

E. STANLEY ABBOT

Medical Corps, U. S. Army

August 29, 1917–December 5, 1918

Captain-Major

Neuropsychiatric service: Survey of students, R. O. T. C., Fort Snelling, Minnesota; Chief of Neuropsychiatric Service, Base Hospital, Camp Sherman, Ohio; Chief of Neuropsychiatric Service, U. S. A. General Hospital No. 26, Fort Des Moines, Iowa; Acting Chief of Medical Service, U. S. A. General Hospital No. 26, Fort Des Moines, Iowa.

HERMAN M. ADLER

Medical Corps, U. S. Army

July 1, 1918–March 1, 1919

Major

Neuropsychiatric service: Study of disciplinary methods in the U. S. Army: Camp Funston, Kansas; Camp Kearney, California; U. S. A. Disciplinary Barracks, Alcatraz, California; Letterman General Hospital, San Francisco, California; Vancouver Barracks, Washington; Camp Lewis, Washington; Fort Jay, New York; and Office of the Surgeon General, Washington, D. C. Director of course in disciplinary psychiatry for psychiatric officers, U. S. A. Disciplinary Barracks, Fort Leavenworth, Kansas.

Major, M. R. C.

LELAND B. ALFORD

Medical Corps, U. S. Navy

August, 1918–May, 1919

Lieutenant (j. g.)

Sea duty, six months.

CHARLES LEWIS ALLEN

Medical Corps, U. S. Army

July 1–October 6, 1918

Contract Surgeon

Neuropsychiatric service: Neuropsychiatric Board, Camp Lewis, Washington; 166th Depot Brigade.

FREDERICK EMERSON ALLEN

Medical Corps, U. S. Army

August 21, 1917–April 20, 1919

Captain–Major

Neuropsychiatric service: Letterman General Hospital, San Francisco, California; U. S. A. Disciplinary Barracks, Alcatraz, California; Fort Winfield Scott, California.

Major, M. R. C.

HENRY D. ALLEN

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Georgia of the American Medico-Psychological Association.

PAUL J. ALSPAUGH

Medical Corps, U. S. Army

September 6–20, 1918

Contract Surgeon

Neuropsychiatric service: Camp Sherman, Ohio.

GEORGE S. AMSDEN

Medical Advisory Board No. 3, New York State.

PAUL V. ANDERSON

Medical Corps, U. S. Army

August 15, 1917–February 3, 1919

1st Lieutenant–Captain

Neuropsychiatric service: New York Neurological Institute, New York City; Camp Greene, North Carolina; Base Hospital, Camp Lee, Virginia; 41st, 3d and 4th Divisions.

A. E. F., France, July 2, 1918–January 16, 1919: Autun and Varvinay; Base Hospitals No. 45 and No. 87, Toul; Army Neurological Hospital No. 2, Toul, and No. 3, Neubecourt.

ERL ARMITAGE BABER

Medical Corps, U. S. Army

October 23, 1918—

Lieutenant—

Neuropsychiatric service: Camp Sherman, Ohio.

Captain, M. R. C.

FRANK STAPLES BACHELDER

Medical Corps, U. S. Army

October 16, 1918—January 31, 1919

Captain

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; U. S. A. General Hospital No. 28, Fort Sheridan, Illinois.

PEARCE BAILEY

Chairman, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Rééducation.

Medical Corps, U. S. Army

July 10, 1917—February 22, 1919

Major-Colonel

Neuropsychiatric service: Chief of the Division of Neurology and Psychiatry, Office of the Surgeon General, Washington, D. C.

A. E. F., France and England, July 9, 1918—October 12, 1918.

Distinguished Service Medal.

AMOS T. BAKER.

Medical Corps, U. S. Army

August 10, 1918—

Captain-Major—

Neuropsychiatric service: Chief of the Department of Psychiatry and Sociology, Atlantic Branch, U. S. A. Disciplinary Barracks, Governor's Island, New York.

Organized above department.

Major, M. R. C.

LOUIS B. BALDWIN

Medical Corps, U. S. Army

January 15, 1918—March 7, 1919

Major—Lt. Colonel

Hospital Division, Office of the Surgeon General, Washington, D. C.

Colonel, M. R. C.

CHARLES R. BALL

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

Medical Corps, U. S. Army

July 10, 1918—March 19, 1919

Captain

Neuropsychiatric service: Camp Grant, Illinois; Camp Jackson, South Carolina.

A. E. F., France, August 21, 1918–March 7, 1919: Base Hospital No. 60, Bazoilles; Consultant in Neurology, American Red Cross Hospital No. 1, Neuilly; Base Hospital No. 9, Chateauroux; Base Hospital No. 214, Savenay.

JAU DON BALL

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from California of the American Medico-Psychological Association.

Contract Surgeon, 2d Officer's Training Camp, The Presidio, San Francisco, California, August, 1917–January, 1918.

Medical Corps, U. S. Army

November 5, 1918–May 5, 1919

Captain

Neuropsychiatric service: Development Battalion, Camp Kearney, California.

THOMAS EDWIN BAMFORD

Draft Board No. 2, Syracuse, New York, 1917–part of 1918.

Medical Corps, U. S. Army

October 1–December 15, 1918

Captain

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York.

CHARLES P. BANCROFT

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from New Hampshire of the American Medico-Psychological Association.

CHARLES A. BARLOW

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from West Virginia of the American Medico-Psychological Association.

Medical Corps, U. S. Army

May 22, 1918–April 19, 1920

Captain–Major

Neuropsychiatric service: Chief of Neuropsychiatric Service, U. S. A. General Hospital No. 4, Fort Porter, New York; Walter Reed General Hospital, Washington, D. C.; U. S. A. General Hospital No. 26, Fort Des Moines, Iowa; and Base Hospital, Fort Sam Houston, Texas.

FRANCIS M. BARNES, JR.

Secretary, Medical Advisory Board No. 4, St. Louis, Missouri, December, 1917–December, 1918.

Medical Corps, U. S. Army

November–December, 1918

Contract Surgeon

Neuropsychiatric service.

WILLIAM NEWTON BARNHARDT

Medical Corps, U. S. Army

September 10, 1917–December 12, 1918

1st Lieutenant–Captain

General medicine and medical supply: Base Hospital, Camp Gordon, Georgia; Infirmary No. 4, Camp Pike, Arkansas.

ALBERT M. BARRETT

Member, Medical Advisory Board, Ann Arbor, Michigan.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Classification of Institutions for Nervous and Mental Disorders, Subcommittee on Neuropsychiatric Instruction.

Medical Corps, U. S. Army

1 year, 4 months

Contract Surgeon

Neuropsychiatric service: Director, Military Neuropsychiatric Training School, State Psychopathic Hospital, Ann Arbor, Michigan; U. S. A. General Hospital No. 30, Plattsburg, New York.

THOMAS MCSWINEY BARRETT

Medical Corps, U. S. Army

September 22, 1917–September 5, 1919

1st Lieutenant–Captain

Neuropsychiatric service: M. O. T. C., Camp Greenleaf, Georgia; Camp Pike, Arkansas; Camp Upton, New York.

Major, M. R. C.

T. B. BASS

Member, Medical Advisory Board No. 2, Texas.

CHRISTOPHER C. BELING

American Red Cross, Home Service Station.

Local Draft Board No. 8, Newark, N. J.

Neuropsychiatric examinations.

JAMES A. BELVEA

Medical Corps, U. S. Army

July 16, 1917–July 31, 1919

Lieutenant–Captain

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; St. Elizabeths Hospital, Washington, D. C.; Camp Sheridan, Alabama; Kelly Field, Texas; Camp Cody, New Mexico; Fort Bliss, Texas; Camp McArthur, Texas.

A. E. F., France and Germany, August 22, 1918–July 31, 1919: Evacuation Hospital No. 15, Glorieux, France; Base Hospital No. 117, Lafauche, France; Base Hospital No. 6, Bordeaux, France; Embarkation Camp No. 2; Base Hospital No. 208, Autun, France; Evacuation Hospital No. 12, Trier, Germany; Evacuation Hospital No. 14, Coblenz, Germany; Evacuation Hospital No. 16, Revigny, France; Base Hospital No. 214, Savenay, France.

INEZ A. BENTLEY

Medical Service, France

October 23, 1918–August 21, 1919

Superintendent, American Women's Hospital, Unit No. 1, Luzancy and Bleiaucourt.

JOSEPH B. BETTS

Medical Corps, U. S. Army

August 21, 1917–May 6, 1919

Captain-Major

Neuropsychiatric service: Fort Porter, New York.

A. E. F., France, November 22, 1917-May 1, 1919: Psychiatric Member, Classification Board, Blois; Commanding Officer, Base Hospital No. 23, Vittel.

Deceased, January 29, 1921

THOMAS C. BIDDLE

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Kansas of the American Medico-Psychological Association.

Deceased, February 16, 1918

LOUIS E. BISCH

Medical Corps, U. S. Navy

August 1, 1917-May 1, 1919

Lieutenant (j. g.)-Lieutenant

Neuropsychiatric service: Director, Psychiatric Division, 5th Naval District, Hampton Roads, Virginia.

JOHN HUDSON BLAUVELT

Special General Medical Examiner, Local Draft Board, Nyack, New York.

EDWIN P. BLEDSOE

Medical Corps, U. S. Army

September 22, 1917-September 30, 1919

Captain

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.; Camp Joseph E. Johnston, Florida; Camp Logan, Texas.

A. E. F., France, April 1-December 24, 1918: Base Hospital No. 202, Orleans; Base Hospital No. 214, Savenay.

EDGAR MAULE BLEW

Medical Corps, U. S. Army

July 1, 1918-May 20, 1919

1st Lieutenant

Neuropsychiatric service: Camp Surgeon's Office, Camp Upton, New York; Adjutant; Camp Psychiatrist; Review Board.

G. ALDER BLUMER

Neurologist, Psychiatrist, and Secretary, First Medical Advisory Board, Rhode Island, 1917-1918.

Member, Executive Committee, Providence (Rhode Island) Chapter, American Red Cross.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; also, representative from Rhode Island of the American Medico-Psychological Association.

EARL DANFORD BOND

Medical Corps, U. S. Army

October 6, 1917-February 17, 1919

Captain-Major

Neuropsychiatric service: Chief of Neuropsychiatric Service and Training School, U. S. A. General Hospital No. 6, Fort McPherson, Georgia; Port Neuropsychiatrist, Port of Embarkation, Newport News, Virginia.

EUGENE D. BONDURANT

Examiner of applicants for commission in M. R. C., two months before entering service.

Medical Corps, U. S. Army

July 12, 1917–March 21, 1919

Major–Lt. Colonel

Neuropsychiatric service: Henry Phipps Psychiatric Clinic, Baltimore, Maryland. Chief of Neuropsychiatric Service, Camp Gordon, Georgia; Camp Stuart, Virginia; and Walter Reed General Hospital, Washington, D. C. Commanding Officer, U. S. A. General Hospital No. 13, Dansville, New York.

PARKER G. BORDEN

Medical Corps, U. S. Army

Lieutenant–Major–

Neuropsychiatric service, A. E. F., France: Base Hospital No. 31, Contrexeville.

U. S. A. General Hospital No. 46, St. Louis, Missouri.

KARL M. BOWMAN

Medical Corps, U. S. Army

July, 1917–June 11, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Casual (examining regiment), Douglas, Arizona; U. S. A. General Hospital No. 6, Fort McPherson, Georgia.

A. E. F., England and France, June, 1918–June, 1919: Casual, British Army, Maghull, England; Admitting Officer, Base Hospital No. 214, Savenay, France.

DAVID TRUMAN BREWSTER, JR.

Medical Corps, U. S. Army

March 19, 1918–August 29, 1919

1st Lieutenant

M. O. T. C., Camp Greenleaf, Georgia; Surgeon, U. S. Transport Service; Port of Embarkation, Hoboken, New Jersey. Escorted sick and wounded U. S. Troops from Port of Debarkation, Hoboken, New Jersey, to U. S. Army camps and hospitals. Office of Attending Surgeon, Port of Debarkation, Hoboken, New Jersey.

Captain, M. R. C.

GEORGE FRANKLIN BREWSTER

Medical Corps, U. S. Navy

April 9, 1917–July 29, 1919

Assistant Surgeon–Passed Assistant Surgeon

Psychiatrist, Naval Training Station, Newport, Rhode Island.

Sea duty, December, 1918–July 29, 1919: U. S. S. Great Northern (transport) and Senior Medical Officer, U. S. S. Santa Paula (transport).

L. VERNON BRIGGS

Contract Surgeon, Medical Corps, U. S. Army, July–August, 1917.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the Subcommittee on Reëducation, of the War Work Committee.

Secretary, Massachusetts War Work Committee.

Medical Corps, U. S. Army
September, 1917–March 24, 1919
Major–Lt. Colonel

Neuropsychiatric service: Division Psychiatrist, 76th Division, Camp Devens, Massachusetts.

A. E. F., France and Germany, July, 1918–February 23, 1919: Division Psychiatrist, St. Amand, Montrond, France; Chief Consultant in Neuropsychiatry, Hospital Center, Commercy, Meuse, France; Division Psychiatrist, Neuwied, Germany.

Lt. Colonel, M. R. C.

SWEPSON J. BROOKS

Medical Corps, U. S. Army
August 15, 1917–August 4, 1919
Contract Surgeon–Captain
Captain, M. R. C.

SANGER BROWN, II

Medical Corps, U. S. Army
July 25, 1917–September 15, 1919
1st Lieutenant–Lt. Colonel

Neuropsychiatric service: Camp Hospital, Gettysburg, Pennsylvania; Office of the Surgeon General, Washington, D. C.

A. E. F., France, May 19, 1918–April 2, 1919: Commanding Officer, Base Hospital No. 214, Savenay.

ALBERT EDWARD BROWNRIGG

Medical Corps, U. S. Army
October 5, 1917–February 1, 1919
Captain–Major

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.; Chief of Neuropsychiatric Service and later Commanding Officer, U. S. A. General Hospital No. 4, Fort Porter, New York.

HOWARD M. BRUNDAGE

Member, Local Draft Board No. 5, Franklin County, Ohio.
Examination of heart, lungs, nervous and mental diseases.

CHARLES H. BRUSH

Medical Corps, U. S. Army
May 27, 1918–
Lieutenant–

Neuropsychiatric service: Camp Dix, New Jersey.

A. E. F., France: Evacuation Hospital No. 28, Nantes.

EDWARD N. BRUSH

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Maryland of the American Medico-Psychological Association.

Member, Medical Advisory Board No. 2, Baltimore, Maryland, August, 1918, until after armistice.

Psychiatric work, Local Board No. 4, Baltimore County, August, 1918, until after armistice.

Member, Volunteer Medical Service Corps.

NATHANIEL H. BRUSH

Neuropsychiatric Examiner, Medical Advisory Board, Baltimore, Maryland, February 15-April 23, 1918.

Medical Corps, U. S. Army, April 24, 1918-September 12, 1919
Captain

Neuropsychiatric service: Camp Psychiatrist and Instructor, M. O. T. C., Camp Greenleaf, Georgia; Chief of Neuropsychiatric Service, Debarkation Hospital No. 51, Hampton, Virginia; Executive Officer, U. S. A. General Hospital No. 43 (formerly Debarkation Hospital No. 51), Hampton, Virginia.

J. M. BUCHANAN

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Mississippi of the American Medico-Psychological Association.

CHARLES M. BURDICK

Assistant to Local Draft Board in registering nearly 1000 patients in the Central Islip (New York) State Hospital.

T. J. W. BURGESS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Canada of the American Medico-Psychological Association.

Medical Corps, Canadian Army
July 9, 1917-
Lt. Colonel-

CLARENCE C. BURLINGAME

American Red Cross, France, September 1-November 9, 1917.

Medical Corps, U. S. Army
November 11, 1917-July 8, 1919
1st Lieutenant-Lt. Colonel
Director, Medical and Surgical Department, American Red Cross, France.

ANNE BURNET

Instructor and inspector of surgical dressings, American Red Cross, June, 1917-September, 1918.

Medical Corps, U. S. Army
September 6, 1918-February 19, 1919
Contract Surgeon

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York.

S. GROVER BURNETT

Medical Advisor, U. S. Selective Service: Medical Advisory Board No. 53, Kansas City, Missouri, December, 1918-December, 1919.

GEOFFREY C. H. BURNS

Medical Corps, U. S. Army
August 9, 1917-
1st Lieutenant-Major-

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; M. O. T. C., Fort Benjamin Harrison, Indiana. Camp Upton, New York; Camp Greene, South Carolina; Camp Funston, Kansas.

C. B. BURR

Chairman, Genesee County (Michigan) Committee, Training Camps Association two First Officers' Training Camps.
Federal Appeal Agent Division No. 1, Flint, Michigan.
Director, Genesee Chapter (Michigan), American Red Cross.
Member, Michigan State Committee and Chairman, Executive Committee, National Council of Defense, Medical Section.
Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Michigan of the American Medico-Psychological Association.
Member, Committee on War Work, American Medico-Psychological Association.

ROBERT MORRIS BUTLER

Medical Corps, U. S. Army
September 5, 1918—
Captain—
Neuropsychiatric service: U. S. A. General Hospital No. 6, Fort McPherson, Georgia; Camp Beauregard, Louisiana.

C. MACFIE CAMPBELL

Instructor, Military Neuropsychiatric Training School, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Maryland.
Medical Corps, U. S. Army
Contract Surgeon
Neuropsychiatric service: U. S. A. General Hospital No. 11, Cape May, New Jersey.

GEORGE B. CAMPBELL

Medical Corps, U. S. Army
September, 1917—January 12, 1919
Captain—Major
Neuropsychiatric service: In charge of psychiatric work at Camp Pike, Arkansas.
A. E. F., England and France, February—December 23, 1918: Maudsley, 4th London General Hospital, England; Commanding Officer, Base Hospital No. 117, Lafauche, France, and Surgeon, 30th Coast Artillery Corps (grouping of Meuse and Moselle), 4th Army Corps Artillery.
Major, M. R. C.

ARTHUR J. CAPRON

Medical Corps, U. S. Army
September 26, 1918—May 22, 1919
Captain
Neuropsychiatric service: U. S. A. General Hospital No. 4, Fort Porter, New York; Port of Embarkation, Hoboken, New Jersey; U. S. A. General Hospital No. 1, Williamsburg, New York.

CHARLES J. CAREY

Member, Medical Advisory Board No. 5, Eastern Shore, Maryland, February, 1918—until close of draft. Neuropsychiatric examinations.

CHESTER LEE CARLISLE

First Aid and Red Cross Lectures, New York State Employees, 1918.

Medical Corps, U. S. Army

November 5, 1918–October 22, 1919

Captain

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York; Fort Slocum, New York.

FRANCIS A. CARMICHAEL

Medical Corps, U. S. Army

September 16–December 11, 1918

Captain

Neuropsychiatric service: Camp Grant, Illinois.

H. B. CARRIEL

Member, Medical Advisory Board District No. 6, Dixon, Illinois.

Neuropsychiatric examinations.

LOUIS CASAMAJOR

Medical Corps, U. S. Army

May 10, 1917–March 28, 1919

Captain–Major

Neuropsychiatric service, A. E. F., France, May 23, 1917–February 1, 1919: Base Hospital No. 2, Etretat; Base Hospital No. 18, Bazoilles.

U. S. A. General Hospital No. 1, Williamsbridge, New York.

LIONEL L. CAZENAVETTE

Instructor, First Aid Division, American Red Cross, New Orleans, Louisiana, during first part of 1917.

Member, Medical Advisory Board District No. 1, Louisiana. Neuropsychiatric examinations.

C. G. CHADDOCK

Volunteer Medical Service Corps.

Local Advisory Board, St. Louis, Missouri. Neuropsychiatric examinations.

3 months.

ROSS McCLURE CHAPMAN

Member, Local Exemption and Advisory Boards, Washington, D. C.

Medical Corps, U. S. Army

April 22, 1918–August 25, 1919

Major

Neuropsychiatric service, A. E. F.: Division Psychiatrist, 6th Division; Evacuation Hospital No. 12, Army of Occupation, Trier, Germany.

Major, M. R. C.

HOWARD TENNYSON CHILD

Medical Corps, U. S. Navy

March 1, 1918–September 24, 1919

Lieutenant (j. g.)–Lieutenant

Neuropsychiatric service: Psychiatrist, General Court-Martial Board, Navy Yard, Boston, Massachusetts.

Sea duty: U. S. S. *Wilhelmina* (transport).

Ward Officer, U. S. Naval Hospital, Ward's Island, New York.

EDMUND A. CHRISTIAN

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

CHARLES H. CLARK

Chairman, Medical Advisory Board No. 11, Lima, Ohio, December 18, 1917–November 11, 1918.

JOSEPH CLEMENT CLARK

Member, Medical Advisory Board No. 7, Maryland.
Volunteer Medical Service Corps.
Local Council of Defense.

L. PIERCE CLARK

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member, Subcommittee on the Smith College Training School for Psychiatric Social Work, of the War Work Committee.

HARRY G. CLARKE

Medical Corps, U. S. Army
August 29, 1917–April 1, 1919
1st Lieutenant–Captain
Neuropsychiatric service: Base Hospital No. 27, Camp Crane, Pennsylvania.
A. E. F., France, September 27, 1917–March 27, 1919: Base Hospital No. 27, Angers; Mobile Hospital No. 1; French ambulances, 3/44 and 2/73.
Review Board (demobilization), Camp Upton, New York.

HOMER E. CLARKE

Member, Medical Advisory Board, Flint, Michigan.

O. H. COBB

Member, Medical Advisory Board No. 36, Syracuse, New York, 1917–1918.

HENRY WALDO COE

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Oregon of the American Medico-Psychological Association.

EUGENE COHN

Member, Medical Advisory Board, Kankakee, Illinois, duration of war. Neuropsychiatric examinations.

FLISHA H. COHOON

Member, Medical Advisory Board District No. 42, Massachusetts, 1917–1918.

ARTHUR B. COLEBURN

Medical Corps, U. S. Army
October 2, 1917–
Captain–
Neuropsychiatric service: Commanding Officer, Enlisted Personnel Detachment, St. Elizabeths Hospital, Washington, D. C.; Psychiatrist, Camp Merritt, New Jersey; in charge of psychiatric work, U. S. A. Debarkation Hospital No. 1, Ellis Island, New York; Chief of Neuropsychiatric Service, U. S. A. General Hospital No. 25, Fort Benjamin Harrison, Indiana; Department of Psychiatry and Sociology, U. S. A. Debarkation Hospital, Fort Leavenworth, Kansas.

WILLIAM ALFRED CONLON

Medical Corps, U. S. Army

August 4, 1917-July 24, 1919

1st Lieutenant-Major

Neuropsychiatric service: M. O. T. C., Fort Benjamin Harrison, Indiana; Camp Taylor, Kentucky (executive and administrative); Camp Psychiatrist, Camp Raritan, New Jersey; Registrar's Censor and Sanitary Inspector, U. S. A. General Hospital No. 39, Long Beach, Long Island, New York.

FRED J. CONZELMANN

Medical Corps, U. S. Army

July 4, 1918-January 30, 1919

Captain

Neuropsychiatric service: Camp Kearney, California.

OWEN COPP

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member, Subcommittee on Legislation and Subcommittee on Classification of Institutions for Nervous and Mental Disorders, of the War Work Committee.

ISADOR H. CORIAT

Neuropsychiatrist, Medical Advisory Board 41-C, Boston, Massachusetts, 1918.

Medical Corps, U. S. Army

August-September, 1917

Contract Surgeon

Neuropsychiatric service: Examiner, National Guard of New England.

WILLIAM BURGESS CORNELL

Frequent clinics, demonstrations, and instruction while serving as Medical Director, New York City Children's Hospital and School, Randall's Island, New York City, during 1917-1918.

Clinics in psychiatry and psychometry for M. R. C., U. S. Army and Navy; also training of Naval Hospital corpsmen.

HERBERT C. DE V. CORNWELL

Medical Corps, U. S. Army

August 9, 1917-June 9, 1919

Captain-Lt. Colonel

M. O. T. C., Fort Benjamin Harrison, Indiana; Regimental Surgeon, 316th Infantry, 79th Division.

A. E. F., July 9, 1918-May 28, 1919: Regimental Surgeon, 316th Infantry, 79th Division.

HENRY A. COTTON

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from New Jersey of the American Medico-Psychological Association.

Medical Corps, U. S. Army

September 5, 1917-

Major-

Neuropsychiatric service: Camp Dix, New Jersey.

HERMAN WALTER COVEY

Medical Corps, U. S. Army

November 1, 1918-

1st Lieutenant-

Neuropsychiatric service: Ward Surgeon and Consultant in Neuropsychiatry, U. S. A. General Hospital No. 26, Fort Des Moines, Iowa, and U. S. A. General Hospital No. 21, Denver, Colorado.

H. IRVING COZAD

Member, Medical Advisory Board No. 1, Akron, Ohio.

JOSEPH S. CRAIG

Medical Corps, U. S. Army

August 4, 1917-April 1, 1919

1st Lieutenant-Captain

Neuropsychiatric service (Air Service): M. O. T. C., Fort Benjamin Harrison, Indiana; Assistant to the Surgeon, Kelly Field, Texas; Neurologist and Psychiatrist, Hospital, Air Service Depot, Garden City, Long Island, New York.

HANSELL CRENSHAW

Medical Corps, U. S. Army

April 25, 1918-

Captain-

Neuropsychiatric service: Base Hospital No. 43

A. E. F., France: Base Hospital No. 43, Blois.

WILLIAM A. CROOKS

Medical Corps, U. S. Army

October 11, 1918-

Captain-

Neuropsychiatric service: Camp Pike, Arkansas.

W. P. CRUMBACKER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Iowa of the American Medico-Psychological Association.

Deceased, May 14, 1920

CLARENCE J. D'ALTON

Medical Corps, U. S. Army

July 9, 1917-May 9, 1919

1st Lieutenant-Captain

Neuropsychiatric service: Boston Psychopathic Hospital, Boston, Massachusetts; Division Psychiatrist, 34th Division, Camp Cody, New Mexico.

A. E. F., France, July 10, 1918-April 30, 1919: Base Hospital No. 117, Lafauche; Division Psychiatrist, 35th and 90th Divisions; Psychiatrist, Headquarters, 1st Army Corps.

IRA A. DARLING

Medical Corps, U. S. Army

July 1, 1918-January 15, 1919

1st Lieutenant

Neuropsychiatric service: Neuropsychiatric Board, Physical Examining Station, Camp Gordon, Georgia; Regimental Surgeon, 138th Field Artillery.

A. E. F., France, September 9-December 23, 1918: Regimental Surgeon, 138th Field Artillery; Base Hospital No. 89, Mesves Hospital Center (Provisional Base Hospital Unit No. 8).

FRED L. DARROW

Medical Corps, U. S. Army

August 12, 1917-

Lieutenant-Captain-

Air service: Field Medical Office, Rockwell Field, San Diego, California.

GEORGE W. DAVIES

Draft Board, 6 months

Medical Corps, U. S. Army

November 1, 1918-February 1, 1919

1st Lieutenant

Neuropsychiatric service: 156th Depot Brigade, Camp Sevier, South Carolina.

HOMER LELAND DAY

Examining Physician, Draft Board No. 161, New York City, from beginning of draft until entering service.

Medical Corps, U. S. Army

September, 1918-

1st Lieutenant-

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York.

WILLIAM D. DEUSCHLE

Chairman, Medical Advisory Board No. 9, Columbus, Ohio.

FREDERICK C. DEVENDORF

Medical Corps, U. S. Army

September 10, 1917-

Captain-

Neuropsychiatric service: Fort Benjamin Harrison, Indiana; Camp McClellan, Alabama; Fort Oglethorpe, Georgia, A. R. C.

A. E. F., France: Base Hospital No. 52, Rimaucourt.

RICHARD DEWEY

Member, Medical Advisory Board No. 1, Milwaukee, Wisconsin.
Neuropsychiatric examinations.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Wisconsin of the American Medico-Psychological Association.

WILLIAM M. DOBSON

Medical Corps, U. S. Army

June 16, 1917-April 24, 1919

1st Lieutenant-Major

Neuropsychiatric service, A. E. F., July 22, 1917-April 17, 1919: Casual attached to British Division and Base Hospital No. 17, Dijon, France; Base Hospital No. 116, Bazoilles.

PERCY L. DODGE

Medical Corps, U. S. Army

July 10, 1917-

1st Lieutenant-

Neuropsychiatric service: Fort Benjamin Harrison, Indiana; Philadelphia General Hospital, Philadelphia, Pennsylvania; charge of neurological work, Base Hospital, Camp Wheeler, Georgia; Fort Screven.

A. E. F., France, August 8, 1918-February 12, 1919: Base Hospital No. 51, Toul.

CHARLES EDWARD DOHERTY

Medical Corps, Canadian Army

August, 1914-January, 1919

Major-Lt. Colonel

France, April-October, 1915: Medical Service

England, October, 1915-August, 1917: A. D. M. S., London.

Canada: O. C. Newmarket Military Hospital; A. D. M. S., Military District No. 11.

Mentioned in Despatches, January, 1917.

Deceased, August 14, 1920

GEORGE DONOHUE

Medical Corps, U. S. Army

September 17-December 1, 1918

Major

Neuropsychiatric service: U. S. A. General Hospital No. 26, Fort Des Moines, Iowa.

GILBERT FRANKLIN DOUGLAS

Medical Corps, U. S. Army

July 25, 1917-July 31, 1919

1st Lieutenant-Captain

M. O. T. C., Camp Greenleaf, Georgia; 313th Infantry, Camp Meade, Maryland.

A. E. F., France, July 8, 1918-March 1, 1919: 313th and 316th Infantry, 79th Division. Detached Service, March 1-July 1, 1919: University of Paris.

RAYMOND F. DOWELL

Medical Corps, U. S. Army

September 13, 1918-June 13, 1919

1st Lieutenant

Neuropsychiatric service: 158th Depot Brigade, Camp Sherman, Ohio; Demobilization Examining Board, Camp Grant, Illinois.

DANA FLETCHER DOWNING

Medical Corps, U. S. Army

September 24, 1918-April 1, 1919

1st Lieutenant

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York; Special Examining Board, Camp Jackson, South Carolina.

WILLIAM FRANCIS DREWRY

Member, Executive Committee, Petersburg (Virginia) Chapter, American Red Cross, 1917-1918.

Medical Advisory Board, Dinwiddie County, Petersburg, Virginia.

Member, Local Medical Defense Committee.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Virginia of the American Medico-Psychological Association.

Member, Virginia Commission on Training Camp Activities, Law Enforcements, and Moral Welfare, 1917-1919.

Medical Corps, U. S. Army

April 30-September 30, 1917

Contract Surgeon

Neuropsychiatric service: Examiner, Virginia National Guard.

H. H. DRYSDALE

Member, Medical Advisory Board No. 6, Cleveland, Ohio. Neuro-psychiatric examinations.

JOHN W. DUKE

Vice-President, Oklahoma Branch, American Red Cross.
Member, Medical Section, State Council of Defense.
Chairman, Western District Exemption Board, Oklahoma.
Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Oklahoma of the American Medico-Psychological Association.
Deceased, October 10, 1920

WILLIAM RUSH DUNTON, JR.

Director, Course in Occupational Therapy, Maryland Institute, October, 1918–February, 1919.
Medical Advisory Board No. 2, Baltimore, Maryland, April–November, 1918. Examination of drafted men for mental and nervous defects.
Assisted in training Reconstruction Aides.
Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member, Subcommittee on Reëducation, of the War Work Committee.

AUGUSTUS B. DYKMAN

Medical Corps, U. S. Army
August 8, 1917–June 23, 1919
1st Lieutenant–Captain
Neuropsychiatric service: New York Neurological Institute, New York City. Special Board of Medical Examiners, Camp Travis, Texas; Kelly Field, Texas; and Camp Pike, Arkansas.
A. E. F., 9 months: Evacuation Hospital No. 27, Coblenz, Germany; 6th Division.

HARRY D. EARL

Secretary, Medical Advisory Board, Jamestown, North Dakota, duration of war.

RICHARD GARDNER EATON

Medical Corps, U. S. Army
August 28, 1917–December 12, 1918
Captain
Neuropsychiatric service: Henry Phipps Psychiatric Clinic, Baltimore, Maryland; St. Elizabeths Hospital, Washington, D. C.; U. S. A. General Hospital No. 5, Fort Ontario, New York; Camp Grant, Illinois.

JOHN L. ECKEL

Secretary, Medical Advisory Board No. 42, Buffalo, New York.

A. BURTON ECKERDT

Civilian Relief, American Red Cross, Helena, Montana.
Examiner, Draft Board.
Medical Corps, U. S. Army
June 1, 1917–February 20, 1919
1st Lieutenant
Special Examiner, M. O. R. C., Helena, Montana; Yale Army Service School; Laboratory, Base Hospital, Camp Lewis, Washington.

WILLIAM W. EICHELBERGER

Examiner, Draft and Exemption Boards, Wisconsin.

Medical Corps, U. S. Army

August 6, 1917–April 15, 1918

Captain

Neuropsychiatric service: New York Neurological Institute, New York City; Camp Funston, Kansas.

EDWARD J. ENGBERG

Medical Corps, U. S. Army

December 13, 1917–May 20, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Philadelphia Post Graduate School, Philadelphia, Pennsylvania; Camp Beauregard, Louisiana; Camp Doniphan, Oklahoma; Neurologist, Base Hospital No. 65.

A. E. F., France, August 30, 1918–February 9, 1919: Registrar, Base Hospital No. 212, Paris; Neurologist, Base Hospital No. 65, Kerhuon.

Chief of Neurological Service, U. S. A. General Hospital No. 36, Detroit, Michigan.

T. W. EVANS

Medical Corps, U. S. Army

June 1, 1917–February 22, 1919

1st Lieutenant–Captain

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; Base Hospital, Fort Sam Houston, Texas; U. S. A. General Hospital No. 30, Plattsburg, New York.

Captain, M. R. C.

EDWARD ALFRED EVERETT

Medical Corps, U. S. Army

October 9, 1918–September 4, 1919

1st Lieutenant

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.; Camp Humphreys, Virginia; Hazelhurst Field, Mineola, Long Island, New York; Medical Research Laboratory, Air Service, Mineola, Long Island, New York.

W. S. FAST

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Nebraska of the American Medico-Psychological Association.

EGBERT W. FELL

Medical Corps, U. S. Army

August 16, 1917–March 20, 1919

Captain–Major

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; Chief, Neuropsychiatric Section, Camp Grant, Illinois; Chief of Neuropsychiatric Service, Base Hospital, Fort Sam Houston, Texas; Chief of Neuropsychiatric Service, Walter Reed General Hospital, Washington, D. C.

WALTER E. FERNALD

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Smith College Training School for Psychiatric Social Work; Subcommittee on Clinical Methods; Subcommittee on Classification of Hospitals; Subcommittee on Reëducation.

ALBERT WARREN FERRIS

"Four Minute" Speaker by appointment of the President, 1 year.
Chairman, Saratoga County (New York) Home Defense Committee.

ALAN DANIEL FINLAYSON

Medical Corps, U. S. Army
January 1, 1918–October 21, 1919
Captain

Neuropsychiatric service: Camp Psychiatrist, Camp Joseph E. Johnston, Florida; Chief of Neuropsychiatric Service and, later, Acting Chief of Medical Service, Base Hospital, Camp Jackson, South Carolina; Ward Surgeon and Member, Disability Board, U. S. A. General Hospital No. 43, Hampton, Virginia.

ELIAS CECIL FISCHBEIN

Medical Corps, U. S. Army
February 2, 1918–September 15, 1919
1st Lieutenant–Captain

Neuropsychiatric service: New York Neurological Institute, New York City; Camp Dix, New Jersey; Chief of Neuropsychiatric Section, Base Hospital, Fort Riley, Kansas; Camp Sherman, Ohio.

E. MOORE FISHER

Member, Advisory Board, Somerset County, New Jersey. Neuropsychiatric examinations.

Assistant Neuropsychiatrist, Advisory Board, Morris County, New Jersey.

February–October, 1918.

Medical Corps, U. S. Army
October 24, 1918–October 25, 1919
Captain

Neuropsychiatric service: Physical Examining Board, Camp Gordon, Georgia.

WALTER ARI FORD

Medical Corps, U. S. Army
June 1, 1917–June 17, 1919
1st Lieutenant–Captain

Neuropsychiatric service: Post Hospital, Fort Sheridan, Illinois; St. Elizabeths Hospital, Washington, D. C.; Camp Joseph E. Johnston, Florida.

A. E. F., France and Germany, July, 1918–May, 1919: Base Hospital No. 53, Langres, France. General Medical Service: 354th Infantry, 1st Battalion, 89th Division, Germany.

Major, M. R. C.

HENRY L. FOUGEROUSSE

Medical Advisory Board, New Orleans, Louisiana. Physical and mental examinations.

Medical Corps, U. S. Navy

August 21, 1918-

Lieutenant (j. g.)-Lieutenant-

Chief of Staff, U. S. Naval Hospital, New Orleans, Louisiana.

HOWARD M. FRANCISCO

Medical Corps, U. S. Army

September 12, 1917-September 9, 1919

Lieutenant-Major

Neuropsychiatric service: University of Pennsylvania, Jefferson and Philadelphia General Hospitals, Philadelphia, Pennsylvania; Survey of Divisions and examinations of draft men, 80th Division, Camp Lee, Virginia, and 36th Division, Camp Bowie, Texas.

A. E. F., 1 year: Division Psychiatrist, 36th Division.

Major, M. R. C.

SHEPHERD I. FRANZ

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member, Subcommittee on Reëducation, of the War Work Committee.

Instructor, Military Neuropsychiatric Training School, St. Elizabeths Hospital, Washington, D. C.

BENJAMIN F. FRAZER

Medical Corps, U. S. Army

October 23, 1918-

1st Lieutenant-

Army Medical School, Washington, D. C.; Ambulance Company 325, Camp Gordon, Georgia.

A. E. F., June 1, 1918-: Ambulance Company 325; Battalion Surgeon, 2d Battalion, 321st Field Artillery.

EDWARD HENRY FRENCH

Medical Corps, U. S. Army

July 30, 1917-July 9, 1919

1st Lieutenant-Captain

Neuropsychiatric service, A. E. F., England, France, Luxembourg, and Germany, 14 months: Maudsley, Neurological Clearing Hospital, London; Second Northern General Hospital (also, general medical (hospitals), field sanitation, and surgery).

JOSEPH C. FULMER

Member, Draft Board No. 2, Williamsport, Pennsylvania, 6 months.

Medical Corps, U. S. Army

October 5, 1918-October 13, 1920

1st Lieutenant

Neuropsychiatric service: Special Examining Boards and Camp Hospitals, Camp Sherman, Ohio; Camp Bowie, Texas; and Camp Pike, Arkansas.

EDGAR BRIGHT FUNKHOUSER

Member, Medical Advisory Board No. 14 (Mercer County), Trenton, New Jersey.

Medical Corps, U. S. Army

August 5–October 17, 1917; September 18, 1918–March 17, 1919

1st Lieutenant–Captain

Neuropsychiatric service: M. O. T. C., Camp Greenleaf, Georgia; special neuropsychiatric examiner, Camp Meade, Maryland; Headquarters, Port of Embarkation, Newport News, Virginia.

Captain, M. R. C.

JAMES J. GABLE

Medical Corps, U. S. Army

March 1, 1918–June 6, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Camp Psychiatrist, Camp Pike, Arkansas.

A. E. F., France, August 30, 1918–May 28, 1919: Evacuation Hospital No. 24, Mesves; Base Hospital No. 214, Savenay.

WILLIAM E. GARDNER

Medical Corps, U. S. Army

September 5–November 30, 1918

Contract Surgeon

Neuropsychiatric service: Consultant in Neuropsychiatry, Base Hospital, Camp Zachary Taylor, Kentucky.

JOHN C. GEORGE

Medical Corps, U. S. Army

October 1, 1917–November 6, 1919

1st Lieutenant–Major

Neuropsychiatric service: New York Neurological Institute, New York City; Division Psychiatrist, 89th Division, Camp Funston, Kansas; U. S. A. General Hospital No. 28, Fort Sheridan, Illinois.

A. E. F., 11 months: Division Psychiatrist, 89th Division.

EDWARD T. GIBSON

Draft Board, Middletown, Connecticut, 1 year before entering service.

Medical Corps, U. S. Army

October 18, 1918–July 11, 1919

1st Lieutenant

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York.

DONALD R. GILFILLAN

Medical Corps, U. S. Army

July 31, 1917–March 27, 1919

Captain–Major

Neuropsychiatric service: Base Hospital, Fort Oglethorpe, Georgia; Division Psychiatrist, 29th Division, Camp McClellan, Alabama.

A. E. F., France, June 14, 1918–March 24, 1919: Division Psychiatrist, 29th Division; Base Hospital No. 214, Savenay.

ANDREW C. GILLIS

Medical Corps, U. S. Army

June 21, 1918–October 25, 1919

Captain–Lt. Colonel

Neuropsychiatric service: Camp Psychiatrist and President, Neuropsychiatric Board, Camp Meade, Maryland.

A. E. F., France, November 13, 1918-June 1, 1919: Consultant in Neuropsychiatry, Justice Hospital Group, Toul, and Beau Desert Hospital Center.

Chief, Neurosurgical Service, U. S. A. General Hospital No. 2, Fort McHenry, Maryland.

JOHN W. GIVENS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Idaho of the American Medico-Psychological Association.

ALFRED GLASCOCK

Medical Corps, U. S. Army

Captain

May 22-October 10, 1918

Neuropsychiatric service: Camp Hancock, Georgia.

A. E. F., France, September-October, 1918: Base Hospital.

Deceased, October 10, 1918

BERNARD GLUECK

Member, Advisory Committee, Westchester County (New York) Draft Board, February-June, 1918

Medical Corps, U. S. Army

July 18-December 5, 1918

1st Lieutenant-Captain

Neuropsychiatric service: Camp Custer, Michigan; Camp Psychiatrist, Camp Crane, Pennsylvania.

ALMON P. GOFF

Medical Corps, U. S. Army

1917-1919

Captain

Philippine Islands and Siberia.

VICTOR LYALL GOODWILL

Medical Corps, Canadian Army

December 4, 1915-December 15, 1919

Captain-Major-

C. E. F., December 4, 1915-August 2, 1919: Medical Board, England (administration); military hospitals and military boards.

D. G. M. S. Office, Ottawa; O. C. Cobourg Military Hospital, A. D. M. S., Military District No. 7.

HAROLD I. GOSLINE

Medical Corps, U. S. Army

August 1, 1917-December 14, 1919

1st Lieutenant-Major

Laboratory service: Rockefeller Institute, New York City; Base Hospital, Camp Sherman, Ohio; Base Hospital No. 56, Camp Wadsworth, South Carolina.

A. E. F., France and Germany, 8 months: Base Hospital No. 56; 3d Army Laboratory.

Major, M. R. C

JAMES L. GREEN

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Arkansas of the American Medico-Psychological Association.

EDWARD C. GREENE

Medical Corps, U. S. Army

July 30, 1917-

Captain-Major-

Regimental Surgeon, 301st Engineers, Camp Devens, Massachusetts.

A. E. F., July 15, 1918-September 15, 1919: Regimental Surgeon, 301st Engineers; Commanding Officer, Camp Hospital No. 1; Evacuation Officer, Hospital Center, Commercy, France; Sanitary Inspector, A. S., S. O. S. Troops, 2d Army Area; Chief of Medical Service, Post Hospital, Is-sur-Tille.

Member S. C. D. Board and Ward Surgeon, U. S. A. General Hospital No. 43, Hampton, Virginia.

RALPH NELSON GREENE

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Florida of the American Medico-Psychological Association.

Medical Corps, U. S. Army

July, 1916-March, 1917; August, 1917-July, 1919

Major

Surgeon, 124th Infantry, Camp Wheeler, Georgia; Aero-Medical Observation, 3d Aero Squadron.

Neuropsychiatric service: Chief of Neuropsychiatric Service, Base Hospital No. 1, Fort Sam Houston, Texas.

HUGH S. GREGORY

Member, Medical Advisory Board No. 33, Ogdensburg, New York. Examination of registrants during entire time of existence of advisory boards.

MENAS S. GREGORY

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

Medical Corps, U. S. Army

September 6, 1917-October 20, 1919

Major-Lt. Colonel

Neuropsychiatric service: Neuropsychiatric Examiner, R. O. T. C., Plattsburg Barracks, New York; Fort Niagara, New York; Camp Dix, New Jersey; and Camp Stuart, Virginia; Chief of Neuropsychiatric Division, Office of the Surgeon, Port of Debarkation, Hoboken, New Jersey.

D. W. GRIFFIN

Chairman, Medical Advisory Board, District No. 22, Oklahoma, duration of war.

Medical Corps, U. S. Army

September 26-October 26, 1918

Contract Surgeon

S. A. T. C.; University of Oklahoma, Norman.

LEWIS V. GUTHRIE

Member, Volunteer Medical Service Corps, West Virginia.

Member, Medical Advisory Board, 3d District, West Virginia.

Member, County Council of Defense, West Virginia.

J. VICTOR HABERMAN

Organization of war contingent for study of shock and war neuroses at College of Physicians and Surgeons, Columbia University, New York City.

Medical Corps, U. S. Army

October 18, 1918-January 6, 1919

Captain

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York.

JOHN F. HACKETT

Medical Corps, U. S. Army

October 23, 1917-June 23, 1919

Lieutenant-Captain

Assistant Chief, Medical Service, Base Hospital, Camp Upton, New York; Chief, Medical Service, Evacuation Hospital No. 31.

A. E. F., France, 9 months: Chief, Medical Service, Evacuation Hospital No. 31, Nantes.

Major, M. R. C.

THOMAS H. HAINES

Member, Committee for the Preparation of Methods for the Psychological Examination of Troops.

Psychological Examiner, Civil Service Employee, Camp Dix, New Jersey, and Port of Embarkation, Newport News, Virginia.

CHARLES W. HALTERMAN

Medical Corps, U. S. Army

August 7, 1918-March 31, 1919

Captain

Neuropsychiatric service: Base Hospitals, Camp Upton, New York, and Camp Shelby, Mississippi.

ARTHUR S. HAMILTON

Secretary, State Committee on Medical Advisory Boards, Minnesota, before entering service.

Medical Corps, U. S. Army

August 3, 1918-July 18, 1919

1st Lieutenant-Major

Neuropsychiatric service: Nervous and Mental Division, Medical Research Bureau, Air Service, Mineola, Long Island, New York; Neurologist to Surgical Service, Walter Reed General Hospital, Washington, D. C.

SAMUEL W. HAMILTON

Medical Corps, U. S. Army

August 18, 1917-September 3, 1919

Captain-Major

Neuropsychiatric service, A. E. F., England, France, and Germany, September, 1917-September 3, 1919: Maudsley Hospital, London; Consultant in Neuropsychiatry, 42d Division, 1st Army Corps, 3d Army.

JAMES S. HAMMERS

Medical Corps, U. S. Army

October, 1917-July, 1919

Captain-Lt. Colonel

Adjutant, Base Hospital, Camp Meade, Maryland.

A. E. F., France, 4 months: Commanding Officer, Base Hospital No. 104, Beau Desert Hospital Center.

Lt. Colonel, M. R. C.

ERNEST M. HAMMES

Neurologist, two special draft boards, September, 1917–August 24, 1918

Medical Corps, U. S. Army

August 24, 1918–May 28, 1919

Captain

Neuropsychiatric service: Base Hospital, Camp Custer, Michigan.

A. E. F., France, 7 months: Neurologist, Base Hospital No. 99, Hyeres.

GRAEME M. HAMMOND

Medical Corps, U. S. Army

April 27, 1917–February 11, 1919

1st Lieutenant–Major

Recruiting for Medical Corps; Mental and Nervous Survey, Militia, New York City; Mental and Nervous Survey 42d Division; Base Hospital, Camp Upton, New York; Camp Psychiatrist, Camp Merritt, New Jersey; Neuropsychiatric Consultant, U. S. A. General Hospital No. 1, Williamsbridge, New York.

Major, M. R. C.

W. H. HANCKER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Delaware of the American Medico-Psychological Association.

EDWARD L. HANES

Medical Corps, U. S. Army

July 12, 1917–March 4, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Examiner in Neuropsychiatry and Consultant, Neurosurgical Service, Base Hospital No. 19; Plattsburg (New York), Washington (D. C.), and Columbus (Ohio) Barracks Enlistment Stations.

A. E. F., France, June 4, 1918–February 12, 1919: Base Hospital No. 19, Vichy; Neuropsychiatric Consultant, Vichy and Mars Hospital Centers.

U. S. A. General Hospital No. 29, Fort Snelling, Minnesota, Reconstruction Camp.

GEORGE GEDDY HANKINS

Medical Corps, U. S. Army

October 15, 1918–August 26, 1919

1st Lieutenant

Neuropsychiatric service: Camp Greene, North Carolina; Camp Wadsworth, South Carolina; U. S. A. General Hospital No. 13, Dansville, New York.

F. W. HARMON

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Ohio of the American Medico-Psychological Association.

MILTON A. HARRINGTON

Royal Army Medical Corps (British).

September 15, 1916–September 15, 1917

Lieutenant

Regimental Medical Officer, attached to artillery.

ISHAM G. HARRIS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

W. H. HATTIE

Medical Corps, Canadian Army

January, 1916–November, 1918

Lieutenant–Captain

A. M. C. Course, Halifax, Nova Scotia; Sanitary Officer, Military District No. 6.

C. FLOYD HAVILAND

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Connecticut of the American Medico-Psychological Association.

WILFRED WETHERILL HAWKE

Medical Corps, U. S. Navy

June 1, 1917–September 26, 1919

Lieutenant (j. g.)–P. A. Surgeon

U. S. Naval Hospital, Philadelphia, Pennsylvania.

Sea duty, April 13–October 22, 1918: Senior Medical Officer, U. S. S. Calamares; October 22, 1918–: Senior Medical Officer, U. S. S. America.

LOUIS K. HENSCHER

Medical Corps, U. S. Army

August 10, 1917–May 7, 1919

1st Lieutenant–Captain

Neuropsychiatric service: New York Neurological Institute, New York City; Base Hospital, Camp Custer, Michigan.

A. E. F., July 14, 1918–March 2, 1919: Base Hospital No. 117, Lafauche, France; Assistant Neuropsychiatrist, 1st Army Corps.

ARTHUR P. HERRING

Medical Corps, U. S. Army

March 2, 1918–May 31, 1920

Captain–Major

Neuropsychiatric service: Chief of Neuropsychiatric service, U. S. A. General Hospital No. 2, Fort McHenry, Maryland.

D. PERCY HICKLING

Medical Corps, U. S. Army

November, 1917

Contract Surgeon

Neuropsychiatric service.

RALPH L. HILL

Medical Corps, U. S. Army

May 29, 1917–February 18, 1919

1st Lieutenant–Major

Neuropsychiatric service: Fort Benjamin Harrison, Indiana; Camp Robinson, Wisconsin; Syracuse, New York; Camp Stuart, Virginia; Camp Dix (Board), New Jersey; U. S. A. General Hospital No. 30, Plattsburg, New York.

CHARLES W. HITCHCOCK

Member, Medical Advisory Board No. 22, Harper Hospital, Detroit, Michigan. Neurologist.

AUGUST HOCH

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods and Subcommittee on Classification of Hospitals.

Deceased, September 25, 1919.

MORGAN B. HODSKINS

Medical Corps, U. S. Army

September 5, 1917–February 10, 1919

Captain–Major

Neuropsychiatric service: Chief of Neuropsychiatric Service, Base Hospital, Camp Devens, Massachusetts.

ERVING HOLLEY

Examiner, Draft Board, New York, before entering service.

Medical Corps, U. S. Army

May 30, 1918–June 20, 1919

Captain–Major

Neuropsychiatric service: Camp Humphreys, Virginia.

A. E. F., France, October 13, 1918–June 18, 1919: Base Hospital No. 131, Mars; Base Hospital No. 41, St. Denis; Staff, Hospital Center, Mars.

Major, M. R. C.

EARL K. HOLT

Medical Corps, U. S. Army

August 15, 1918–

1st Lieutenant–

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; U. S. A. General Hospital No. 13, Dansville, New York; U. S. A. General Hospital No. 5, Fort Ontario, New York.

W. M. HOTCHKISS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from North Dakota of the American Medico-Psychological Association.

ADAMS B. HOWARD

Member, Medical Advisory Board No. 2, Cleveland, Ohio. Neuropsychiatric examinations.

HENRY HUN

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

RICHARD H. HUTCHINGS

Medical Corps, U. S. Army

August 30, 1917–February 8, 1919

Captain–Major

Neuropsychiatric service: In charge of neuropsychiatric work, 81st Division, Camp Jackson, South Carolina; Division of Neurology and Psychiatry, Office of the Surgeon General, Washington, D. C.; U. S. A. General Hospital No. 30, Plattsburg, New York.

HENRY A. HUTCHINSON

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Pennsylvania of the American Medico-Psychological Association.

ARTHUR G. HYDE

Member, Medical Advisory Board No. 4, Canton, Ohio.

GEORGE E. HYDE

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Utah of the American Medico-Psychological Association.

SMITH ELY JELLIFFE

Medical Corps, U. S. Army
July 1-September 10, 1918
Contract Surgeon
U. S. A. General Hospital No. 30, Plattsburg, New York.

BERTRAND L. JONES

Medical Advisory Board No. 22, Ann Arbor, Michigan. Neuro-
psychiatric examinations.

KENNETH B. JONES

Medical Corps, U. S. Army
July 25, 1917-
1st Lieutenant-Major-
Neuropsychiatric service, A. E. F., Wales, Italy, France, and Ger-
many, August 17, 1917-August 8, 1919: British Psychiatric
Service (September 1, 1917-March 1, 1918); Welsh War Hos-
pital, Cardiff, Wales; Base Hospital No. 116 Bazailles, France;
Base Hospital No. 117, Lafauche, France; Base Hospital No. 214,
Savenay, France; Division Psychiatrist, 2d Division. (Six months
at front doing general medical work.)
Camp Examining Board, Camp Dix, New Jersey; Fort Bliss,
Texas.

WILLIAM A. JONES

Member, Medical Advisory Board No. 16, Minneapolis, Minnesota.
Neuropsychiatric examinations.

MICHAEL M. JORDAN

Advisory Board, Hudson, Massachusetts, November, 1917-July 17,
1918.

Medical Corps, U. S. Army
July 17, 1918-October 3, 1919
Captain

Neuropsychiatric service: Camp Examining Board and Chief of
Neuropsychiatric Service, Base Hospital, Camp Wadsworth, South
Carolina.

Major, M. R. C.

MORRIS J. KARPAS

Medical Corps, U. S. Army
October 1, 1917-July 4, 1918
Captain-Major

Neuropsychiatric service: Camp Mills, New York; Camp Zachary
Taylor, Kentucky; Camp Crane, Pennsylvania.

A. E. F., France, May-July, 1918: Base Hospital No. 117,
Lafauche; Base Hospital No. 214, Savenay.

Deceased, July 4, 1918

HARRY W. KEATLEY

Medical Examiner, O. T. C., Huntington, West Virginia, April, 1917.

Medical Corps, U. S. Army
April 27, 1917-August 1, 1919
1st Lieutenant-Captain

M. O. T. C., Fort Benjamin Harrison, Indiana; Regimental Surgeon,
150th Infantry; Battalion Surgeon, 113th Engineers.

A. E. F., France and Germany, September 5, 1918-June 19, 1919:
Battalion Surgeon, 113th Engineers.

Atlantic Branch, U. S. A. Disciplinary Barracks, Governor's Island,
New York.

DAVID H. KELLER

Medical Corps, U. S. Army

June 1, 1917–February 28, 1919

Lieutenant–Captain

Neuropsychiatric service: M. O. T. C., Fort Riley, Kansas; Neuropsychiatric Board, Camp Funston, Kansas; Chief of Neuropsychiatric Service, Base Hospital, Camp Cody, New Mexico.

Captain, M. R. C.

HOWARD M. KENYON

Medical Corps, U. S. Army

October 26–December 20, 1918

1st Lieutenant

M. O. T. C., Camp Greenleaf, Georgia (as student, later as quiz master).

W. B. KERN

Member, Board, Division No. 5, Los Angeles, California, during entire war period, subject to call of Chairman of Local Board.

JOHN JOSEPH KINDRED

Chairman, Queens and Nassau Counties (New York), Council of National Defense, New York State Branch.

Member, Volunteer Medical Service Corps, duration of war.

G. G. KINEON

County Chairman, American Red Cross, 12 months.

Chairman, Local Board, Gallipolis, Ohio, duration of war.

ROBERT KING

Medical Corps, U. S. Army

October 1, 1917–March 24, 1919

Captain

Neuropsychiatric service: Camp Wheeler, Georgia; Fort Riley, Kansas.

ALFRED C. KINGSLEY

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Arizona of the American Medico-Psychological Association.

GEORGE H. KIRBY

Member, Executive Committee of the War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Classification of Institutions for Nervous and Mental Disorders.

Director, Military Neuropsychiatric Training School, Psychiatric Institute, Ward's Island, New York City.

Medical Corps, U. S. Army

August 22, 1918–March 28, 1919

Major

Neuropsychiatric service: Chief of Neuropsychiatric Service, U. S. A. General Hospital No. 1, Williamsbridge, New York.

GEORGE M. KLINE

Member, Committee on War Work, American Medico-Psychological Association.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; Chairman, Subcommittee on Legislation, and member, Subcommittee on Classification of Institutions for Nervous and Mental Disorders, of the War Work Committee.

LAWRENCE KOLB

U. S. Public Health Service

Assistant Surgeon-Passed Assistant Surgeon

Neuropsychiatric service: In charge of hospital for psychoneuroses, U. S. Public Health Service Hospital, Waukesha, Wisconsin, since its opening until May, 1919.

WILLIAM THEODORE KRADWELL

Contract Surgeon, Medical Corps, U. S. Army, July 8-August 15, 1919.
Advisory Board No. 4, Wilwaukee, Wisconsin, 6 weeks.

Medical Corps, U. S. Army

October 25, 1918-September 30, 1919

Captain

Neuropsychiatric service: Camp Custer, Michigan; U. S. A. General Hospital No. 13, Dansville, New York; Walter Reed General Hospital, Washington, D. C.

WALTER EMERY LANG

Medical Corps, U. S. Army

August 4, 1917-June 3, 1919

1st Lieutenant-Major

M. O. T. C., Camp Greenleaf, Georgia (August 4-November 3, 1917).

FRANK W. LANGDON

Special correspondent on information relative to distribution of surgeons for neurologic surgery and special consultant on medical personnel of neuropsychiatric units, Office of the Surgeon General, Washington, D. C., April 12, 1917-October, 1918.

Consultant on surgeons for neuropsychiatric service, War Work Committee, American Neurological Association; War Work Committee, The National Committee for Mental Hygiene; and Council of National Defense.

U. S. Selective Service: Member and Chairman of Medical Advisory Board No. 5, Ohio, December 18, 1917-March 17, 1919.

FREDERICK ERNEST LAWLOR

Medical Corps, Canadian Army

December 5, 1914-August 26, 1919

Lieutenant-Captain

Officer commanding Nova Scotia Military Hospital, Halifax (mental and contagious disease).

SHAILER E. LAWTON

Medical Advisory Board No. 2, Windham and Windsor Counties, Vermont. Neuropsychiatric examinations.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Vermont of the American Medico-Psychological Association.

SYLVESTER R. LEAHY

Medical Corps, U. S. Army

August 24, 1918–September 30, 1919

Captain

Neuropsychiatric service: Chief of Neuropsychiatric Service, U. S. A. Debarkation Hospital No. 1, Ellis Island, New York; Assistant to the Chief, Neuropsychiatric Division, Office of the Surgeon, Port of Embarkation, Hoboken, New Jersey; Chief of Neuropsychiatric Service, U. S. A. General Hospital No. 1, Williamsbridge, New York.

R. LEIGHTON LEAK

Neuropsychiatrist, Medical Advisory Board, 2d District, Columbia, South Carolina.

Consulting Psychiatrist, Advisory Board No. 3, South Carolina.

SAMUEL C. LINDSAY

Medical Corps, U. S. Army

December 13, 1917–July 28, 1919

Captain-Major

Neuropsychiatric service: Philadelphia General Hospital, Philadelphia, Pennsylvania; Neuropsychiatric Examiner, Camp Stuart, Virginia; Division Psychiatrist, 78th Division, Camp Dix, New Jersey.

A. E. F., France, 13 months: Chairman, Board of Reclassification of Combat Officers, Blois.

WILLIAM S. LINDSAY

1st District Appeal Board, Kansas, 1 year, 3 months.

HERSEY G. LOCKE

Aviation Examining Board, Syracuse, New York, 3 months. Neuropsychiatric examinations.

Medical Corps, U. S. Army

August 27–December 20, 1918

Contract Surgeon

Neuropsychiatric service: Camp Psychiatrist, Syracuse Recruit Camp, New York.

THOMAS LEE LONG

Medical Corps, U. S. Army

January 9, 1918–

Captain-Major–

Air service: Aviation Camp, Waco, Texas; Camp Greene, North Carolina; Mitchel Field, Long Island, New York; Regimental Surgeon, Post Surgeon, and Chief Examiner for Board of Demobilization.

W. F. LORENZ

Medical Corps, U. S. Army

July 15, 1917–May 17, 1919

Major

Commanding Officer, Field Hospital, Company 127, 32d Division.

A. E. F., France and Germany, February 17, 1918–May 5, 1919: Commanding Officer, Field Hospital, Company 127, 32d Division; Triage; Advanced Surgical Field Hospital.

CHARLES R. LOWE

Medical Corps, U. S. Army
September 4, 1918-June 18, 1919
Captain
Neuropsychiatric service: Camp Kearney, California.

WILLIAM McDONALD, JR.

Medical Corps, U. S. Army
May 27, 1918-October 16, 1919
Captain-Major
Neuropsychiatric service, A. E. F., France and Germany, August 31, 1918-April 28, 1919: Base Hospital No. 81, Bazoilles, France; Mobile Hospital No. 6; Mobile Hospital No. 8; Evacuation Hospital No. 8, Mayen, France; Base Hospital No. 65, Kerhuon, France; Evacuation Hospital No. 18, Briey, Germany; Base Hospital No. 214, Savenay, France.

JAMES F. McFADDEN

Medical Corps, U. S. Army
September 5, 1917-May 16, 1919
1st Lieutenant-Captain
Neuropsychiatric service: Chief of Neuropsychiatric Service, Jefferson Barracks, Missouri; Camp Psychiatrist, Camp Grant, Illinois; U. S. A. General Hospital No. 30, Plattsburg, New York; U. S. A. General Hospital No. 1, Williamsbridge, New York.

JOHN IRVINE MCKELWAY

Home Service Section, American Red Cross, prior to entering service.
Medical Corps, U. S. Army
October 15-December 2, 1918
1st Lieutenant
M. O. T. C., Fort Riley, Kansas (Field Service Course).

GEORGE EDWIN MCPHERSON

Medical Corps, U. S. Army
May 20, 1918-May 24, 1919
Major
Neuropsychiatric service: Camp Meade, Maryland; Camp Psychiatrist, Camp Upton, New York, and Camp Gordon, Georgia; Division Psychiatrist, 98th Division, Camp McClellan, Alabama; in charge, Section No. 2, U. S. A. General Hospital No. 30, Plattsburg, New York; Chief of Neuropsychiatric Service, U. S. A. General Hospital No. 34, East Norfolk, Massachusetts.
Major, M. R. C.

JOHN T. MACCURDY

Clinical investigation of war neuroses, British hospitals, 1917.
Medical Corps, U. S. Army
December 15, 1917-February 26, 1919
1st Lieutenant-Captain
Neuropsychiatric service, A. E. F., February 8, 1918-February 3, 1919: Base Hospital No. 17, Dijon, France; Division Psychiatrist, 26th and 1st Divisions; Consultant, Efficiency Board, Blois, France.

WILLIAM A. MACINTYRE

Medical Corps, U. S. Army

March 21, 1918-January 12, 1919

1st Lieutenant

Neuropsychiatric service: New York Neurological Institute, New York City; Camp Gordon, Georgia.

A. E. F., England and France, July 1-December 29, 1918: Maudsley Neurological Clearing Hospital, London; Base Hospital No. 117, Lafauche, France; Army Neurological Hospital No. 1, Benoitevaut, France; Base Hospital No. 214, Savenay, France.

U. S. A. General Hospital No. 25, Fort Benjamin Harrison, Indiana.

GEORGE A. MACIVER

Medical Corps, U. S. Army

August 10, 1917-October 13, 1919

1st Lieutenant-Major

Neuropsychiatric service: Camp Curtis Guild, Massachusetts; Camp Bartlett, Massachusetts; Base Hospital, Camp Travis, Texas; Division Psychiatrist, 90th Division.

A. E. F., France, 1 year, 3 months: Division Psychiatrist, 90th Division; Camp Surgeon, Fort Federes.

Major, M. R. C.

CLIFFORD W. MACK

Medical Corps, U. S. Army

September 7, 1917-April 30, 1919

Lieutenant-Captain

Neuropsychiatric service: Fort McDowell, California.

A. E. F., England and France. February 15, 1918-February 11, 1919: Maudsley Hospital, London; Medical Consultant Service, 25th Division, B. E. F.; Assistant to Senior Consultant in Neuropsychiatry, A. E. F.

Letterman General Hospital, San Francisco, California.

DANIEL C. MAIN

Medical Corps, U. S. Army

October 18, 1918-August 15, 1919

Captain

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.

Major, M. R. C.

ADELBERT C. MATTHEWS

Medical Corps, U. S. Army

Recommended for commission, rank of Captain, just previous to signing of armistice.

GEORGE H. MAXFIELD

Medical Corps, U. S. Army

June 23-December 30, 1919

Captain

M. O. T. C., Camp Greenleaf, Georgia (Cardio-vascular course); Base Hospital No. 135.

Captain, M. R. C.

HERMAN F. MAY

Assistant to Local Draft Board, Buffalo, New York

Medical Corps, U. S. Army

August 21, 1917–March 26, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Base Hospital No. 23.

A. E. F., France, November 21, 1917–March 20, 1919: Base Hospitals No. 23, Vittel, No. 8 and No. 24, Savenay.

JAMES V. MAY

Medical Corps, U. S. Army

August 1–October 7, 1917

1st Lieutenant–Major

Neuropsychiatric service: Camp Devens, Massachusetts.

EDWARD E. MAYER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

L. C. MEAD

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from South Dakota of the American Medico-Psychological Association.

Deceased, January 10, 1920

PAUL B. MEANS

Medical Corps, U. S. Army

August 8, 1918–June 26, 1919

1st Lieutenant

Neuropsychiatric service: Fort Slocum, New York; Camp Humphreys, Virginia; Port of Debarkation, Hoboken, New Jersey.

GEORGE M. MELVIN

Medical Corps, U. S. Army

July 18, 1918–June 23, 1919

1st Lieutenant

Neuropsychiatric service: Camp Hancock, Georgia; Base Hospital, Fort Sam Houston, Texas.

ADOLF MEYER

Consultant, Medical Advisory Board No. 3, Baltimore, Maryland, duration of war.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Classification of Institutions for Nervous and Mental Disorders.

Medical Corps, U. S. Army

September–December, 1917

Contract Surgeon

Neuropsychiatric service: Director, Military Neuropsychiatric Training School, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Maryland.

JOSEPH CLEMENT MICHAEL

Medical Corps, U. S. Army

January 15, 1918–August 26, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Camp Funston, Kansas; Base Hospital, Fort Riley, Kansas.

A. E. F., France, September 15, 1918–August 26, 1919: Base Hospital No. 54, Mesves; U. S. Camp Hospital No. 4; Evacuation Hospital No. 27, Angers; University of Paris (neuropathology and clinical neurology); American Peace Commission, Paris.

FRANK M. MIKELS

Medical Corps, U. S. Army

Recommended for commission as Captain just previous to signing of armistice.

Captain, M. R. C.

FISHER B. E. MILLER

Medical Corps, U. S. Army

December 13, 1917–October 4, 1919

1st Lieutenant

Neuropsychiatric service: Evacuation Hospital No. 12; 33d Division, Camp Logan, Texas; 39th Division, Camp Beauregard, Louisiana.

A. E. F., France and Germany, August 14, 1918–September 10, 1919: Evacuation Hospitals No. 12 and No. 3, Trier, Germany; Base Hospital No. 117, Lafauche, France; Base Hospital No. 214, Savenay, France; 28th Infantry, 1st Division.

JAMES W. MILLIGAN

Medical Advisory Board, Madison, Indiana, from its organization until its close.

CHARLES KARSNER MILLS

Instructor, Military Neuropsychiatric School, Philadelphia General Hospital, Philadelphia, Pennsylvania.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

H. W. MITCHELL

Chairman, County Chapter (Warren, Pennsylvania) American Red Cross, 18 months.

Chairman, Committee on War Work, American Medico-Psychological Association.

Member, Subcommittee on Classification of Institutions for Nervous and Mental Disorders, War Work Committee, The National Committee for Mental Hygiene, New York City.

ROY E. MITCHELL

Member, Medical Advisory Board, Eau Claire District, Wisconsin, December, 1917–November, 1918. General and neuropsychiatric examinations.

FREDERICK PAUL MOERSCH

Medical Corps, U. S. Army

September 1, 1917–July 23, 1919

Lieutenant–Captain

Neuropsychiatric service: State Psychopathic Hospital, Ann Arbor, Michigan; Base Hospital, Camp Upton, New York.

ARTHUR S. MOORE

Medical Corps, U. S. Army
July 14, 1917-June 22, 1919
Captain-Major

M. O. T. C., Fort Benjamin Harrison, Indiana; Instructor, Medical Department Training Units, Fort Ethan Allen, Vermont; Commanding "M" and "H" Companies, Medical Department Training Units, Fort Ethan Allen, Vermont; Assistant to Post Surgeon, Neurologist and Psychiatrist, Post Hospital, and Instructor, Medical Officers' Training School, Fort Ethan Allen, Vermont; Commanding Officer, Medical Department, Training Camp, Fort Ethan Allen, Vermont.

Neuropsychiatric service: Camp Stuart, Virginia; President of Disability Board and President of Neuropsychiatric Board, Port of Embarkation, Newport News, Virginia (Camps Stuart, Morrison, and Hill); Neuropsychiatric Examiner, Assistant to Camp Surgeon, President of Disability Board, and Executive Officer, Camp Hospital, Camp Humphreys, Virginia; President of Neuropsychiatric Board, Camp Lee, Virginia; Neuropsychiatrist, Medical Research Laboratory, Mineola, Long Island, New York; Camp Psychiatrist, Camp Custer, Michigan; Division Psychiatrist, 14th Division (attached to Field Hospital No. 253, 14th Sanitary Train), Camp Custer, Michigan; Chief Medical Examiner and President, Board of Review, Demobilization Medical Board, Camp Custer, Michigan; President of Special and Disability Boards, Camp Custer, Michigan; Chief Medical Examiner, Demobilization and Special Medical Boards, 160th Depot Brigade, Camp Custer, Michigan.

Lt. Colonel, M. R. C.

JOSEPH W. MOORE

Medical Corps, U. S. Army
January 12, 1918-June 14, 1919
Captain-Major

Neuropsychiatric service: Neuropsychiatric Board, examining 39th Division, Camp Beauregard, Louisiana; Psychiatrist, U. S. A. Disciplinary Barracks, Fort Leavenworth, Kansas.

A. E. F., England and France, June 12, 1918-June 12, 1919: Seale Hayne Military (British) Hospital, England; Division Psychiatrist, 80th Division; Chief of Medical Service, Base Hospital No. 214, Savenay, France.

ANGUS W. MORRISON

Medical Corps, U. S. Army
December 13, 1917-March 14, 1919
Captain

Neuropsychiatric service: U. S. A. General Hospital No. 29, Fort Snelling, Minnesota.

A. E. F., France, June 5, 1918-March 9, 1919: Neurologist, Base Hospital No. 26, Allerey; Consultant in Neuropsychiatry, Hospital Center, Allerey.

EUGENE H. MULLAN

U. S. Public Health Service
Assistant Surgeon-Surgeon

Neuropsychiatric service: Psychiatrist, U. S. Marine Hospital, New York; served on army transport to Bahama Islands to obtain laborers for army construction corps.

JAMES FREDERICK MUNSON

Medical Corps, U. S. Army

April 17–October 25, 1918

Captain

Neuropsychiatric service: New York Neurological Hospital, New York City; Camp Lee, Virginia; U. S. A. General Hospital No. 30, Plattsburg, New York.

Deceased, October 25, 1918

GLENN EDWIN MYERS

Medical Corps, U. S. Army

April 21, 1918–August 18, 1919

1st Lieutenant–Captain

Neuropsychiatric service: Camp Lewis, Washington; Camp Fremont, California; Chief of Neuropsychiatric Service, Letterman General Hospital, San Francisco, California.

B. ROSS NAIRN

Member, Medical Advisory Board No. 1, Buffalo, New York.

Medical Corps, U. S. Army

September, 1918–September, 1919

Captain

Neuropsychiatric service: Base Hospital No. 105; Chief of Neuropsychiatric Service, Base Hospital, Camp Dodge, Iowa; U. S. A. General Hospital No. 5, Fort Ontario, New York.

JAMES J. NEELY

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Tennessee of the American Medico-Psychological Association.

MARY LAWSON NEFF

Member, Medical Advisory Board No. 2, Phoenix, Arizona. Neurology and psychiatry.

Commissioned as "Lecturer," Social Hygiene Division of Training Camp Commission, War Department.

Member, Woman's Committee, Council of National Defense, Arizona, in charge of "Americanization" work in State.

THEODORE WILLIAM NEUMANN

Medical Corps, U. S. Army

August 10, 1918–

1st Lieutenant–

Neuropsychiatric service: Camp Gordon, Georgia; Port of Debarkation, Hoboken, New Jersey; U. S. A. General Hospital No. 1, Williamsbridge, New York.

FRANK PARSONS NORBURY

Member, Medical Advisory Board No. 15, Springfield, Illinois.

Acting Medical Director, The National Committee for Mental Hygiene, New York City, August 1, 1918–May 1, 1919.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the Subcommittee on Classification of Institutions for Nervous and Mental Disorders and of the Subcommittee on Legislation, of the War Work Committee.

JOHN DANIEL O'BRIEN

Medical Corps, U. S. Army

September 1, 1917-May 23, 1919

Lieutenant-Lt. Colonel

Neuropsychiatric service: M. O. T. C., Fort Benjamin Harrison, Indiana; Camp Psychiatrist, Camp Sherman, Ohio; Division Psychiatrist, 83d Division, Camp Sherman, Ohio.

A. E. F., May 29, 1918-May 18, 1919: Division Psychiatrist, 83d Division.

JOHN F. O'BRIEN

Medical Corps, U. S. Army

1 month

Contract Surgeon

Neuropsychiatric service: 6th Regiment Infantry, Massachusetts National Guard, Ayer, Massachusetts.

MICHAEL OSNATO

Neuropsychiatrist, Lincoln Hospital Advisory Board, New York City.

Medical Corps, U. S. Army

June 11, 1918-February 19, 1919

Captain

Neuropsychiatric service: Base Hospital No. 102.

A. E. F., Italy, August 4, 1918-February 7, 1919: Base Hospital No. 102, Vercenza; Italian Medical Service (detached).

ALFRED J. OSTHEIMER

Medical Corps, U. S. Army

May 30, 1917-August 7, 1919

Major-Lt. Colonel

M. O. T. C., Camp Greenleaf, Georgia; Regimental Surgeon, 23d and 49th Infantries.

A. E. F., France, September 3, 1919-: Neuropsychiatrist, Base Hospital No. 34, and Consultant Neuropsychiatrist, Hospital Center, Nantes.

Lt. Colonel, M. R. C.

WALTER JOSEPH OTIS

Examiner and Instructor, American Red Cross, Metropolitan District, Boston, Massachusetts.

Medical Corps, U. S. Army

September 22, 1917-March 12, 1919

1st Lieutenant-Major

Neuropsychiatric service: Camp Meade, Maryland; Camp McClellan, Alabama; Camp Taylor, Kentucky; Camp Sherman, Ohio; Camp Mills, New York; Chief of Neuropsychiatric Service, Recruit Depot, Fort Slocum, New York; Special School, Gas, Flame, and Smoke, 84th Division, Camp Sherman, Ohio; Division Psychiatrist, 29th and 84th Divisions.

A. E. F., France, September, 1918-February, 1919: Division Psychiatrist, 84th Division; Base Hospital No. 117, Lafauche; Base Hospital No. 214, Savenay; physician to village sick, Village of Neuvic, S. Lisle, Dordogne; Commanding Officer, Military Hospital, St. Vincent Du Salambre.

WINFRED OVERHOLSER

Medical Corps, U. S. Army

February 4, 1918-June 22, 1919

1st Lieutenant

Neuropsychiatric service: New York Neurological Institute, New York City; Camp Upton, New York.

A. E. F., France and Germany, 5 months: Evacuation Hospital No. 9, Coblenz, Germany (general medicine); Base Hospital No. 117, Lafauche, France.

U. S. A. General Hospital No. 34, East Norfolk, Massachusetts.

FREDERIC H. PACKARD

Member, Medical Advisory Board No. 37, Massachusetts.

FREDERICK W. PARSONS

Medical Corps, U. S. Army

July 29, 1917-March 19, 1919

Captain-Lt. Colonel

Neuropsychiatric service, A. E. F., England and France, 19½ months: Maudsley, 4th London General Hospital, England; British Army; Division Psychiatrist, 1st Division; Commanding Officer, Base Hospital No. 117, Lafauche, France.

W. D. PARTLOW

Chairman, Medical Advisory Board, Alabama, from beginning to end of draft.

C. J. PATTERSON

Commissioned Captain, M. R. C. Directed by Surgeon General to decline acceptance of commission and remain on duty at Marshall Sanitarium, Troy, New York.

GUY PAYNE

Draft Board, May, 1918-November 1, 1919.

Medical Corps, U. S. Army

November 1, 1918-May 23, 1919

Captain

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.; Camp Humphreys, Virginia; U. S. A. Debarkation Hospital No. 51, Hampton, Virginia; U. S. A. General Hospital No. 43, Hampton, Virginia.

MARTIN W. PECK

Medical Corps, U. S. Army

May 2, 1918-March 27, 1919

1st Lieutenant

Neuropsychiatric service: Camp Meade, Maryland; Camp Lee, Virginia; U. S. A. General Hospital No. 30, Plattsburg, New York; Camp Jackson, South Carolina; Camp Meigs, District of Columbia.

CLARENCE PIERSON

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Louisiana of the American Medico-Psychological Association.

CHARLES W. PILGRIM

Member, Subcommittee on Legislation of the War Work Committee, The National Committee for Mental Hygiene, New York City.

ERNEST M. POATE

Medical Corps, U. S. Army

October 9, 1918-January 24, 1919

1st Lieutenant

Battalion Surgeon, Camp Devens, Massachusetts.

Neuropsychiatric service: U. S. A. General Hospital No. 34, East
Norfolk, Massachusetts.

CARLYLE A. PORTEOUS

Medical Corps, Canadian Army

July 9, 1917-

Major-

Pension Board.

WILLIAM C. PORTER

Medical Corps, U. S. Army

September 12, 1918-

1st Lieutenant-Captain-

Neuropsychiatric service: New York Neurological Institute, New
York City; Camp Dix, New Jersey.

FREDERICK C. POTTER

Medical Corps, U. S. Army

July 29, 1918-October 28, 1919

1st Lieutenant

Neuropsychiatric service: U. S. A. General Hospital No. 11, Camp
May, New Jersey; U. S. A. General Hospital No. 41, Fox Hills,
Staten Island, New York.

Captain, M. R. C.

JOHN PRESTON

Member, War Work Committee, The National Committee for Mental
Hygiene, New York City, representative from Texas of the
American Medico-Psychological Association.

GORDON PRIESTMAN

Medical Corps, U. S. Army

July 18, 1918-July 7, 1919

Captain

Neuropsychiatric service: Headquarters, Camp Hancock, Georgia;
Camp Greene, North Carolina; Base Hospital No. 120, Camp
Beauregard, Louisiana.

A. E. F., France, November 10, 1918-June 24, 1919: Ward Sur-
geon, Base Hospital No. 120, Kerhuon.

W. H. PRITCHARD

Medical Corps, U. S. Army

September, 1918

Contract Surgeon

Neuropsychiatric service: Neuropsychiatric Board of Examination,
Camp Sherman, Ohio.

THOMAS P. PROUT

Member, Medical Advisory Board, Union County, New Jersey. Neuro-
psychiatric examinations.

HARRY D. PURDUM

Draft Board, Sykesville, Maryland, April, 1917-October 23, 1918.

Medical Corps, U. S. Army

October 23, 1918-January 2, 1919

Captain

Neuropsychiatric service: Camp Greene, North Carolina; Chief of Staff and Chairman of S. C. D. Board, U. S. A. General Hospital No. 34, East Norfolk, Massachusetts.

FRANK W. QUIN

Member, Medical Advisory Board, 5th Louisiana District.

Medical Corps, U. S. Navy

October 2, 1918-

Lieutenant-

Naval Surgeon, U. S. Naval Station, New Orleans, Louisiana.

Sea duty, U. S. S. Santa Barbara (transport; 5 months).

JAMES H. RANDOLPH

Advisory Board, Jacksonville, Florida. Neuropsychiatric examinations.

THOMAS A. RATLIFF

Medical Corps, U. S. Navy

November 1, 1917-May 1, 1919

Lieutenant (j. g.)-Lieutenant

Psychiatric Division, U. S. Naval Training Station, Hampton Roads, Virginia.

MORTIMER WILLIAMS RAYNOR

Medical Corps, U. S. Army

September 1, 1917-January 22, 1919

Captain-Major

Neuropsychiatric service: Camp Psychiatrist, Camp Meade, Maryland.

A. E. F., July 10, 1918-January 22, 1919: Division Psychiatrist, 79th Division.

RALPH WALLACE REED

Medical Corps, U. S. Army

July 14-December 26, 1918

Captain

Instructor, 6th and 7th Battalions, M. O. T. C., Camp Greenleaf, Georgia.

EVA C. REID

American Red Cross, France

April 3, 1918-January 25, 1919

Children's Bureau: In charge of clinic for women and children, Paris; American Red Cross Hospital No. 2, Paris. Administered to the sick in the epidemic of influenza and typhoid fever in the colony of refugees at St. Maxima, France. Transferred to French Military; "Chef de Service," Base Hospital No. 31, Sens.

Awarded French Medal of Honor. The citation, sent by the French Government to Dr. Reid, reads as follows:

"In the name of the President of the Republic of France, the Minister of War has awarded a Medal of Honor in silver to Eva C. Reid, Doctor of Medicine, of the American Red Cross. In the course of a severe epidemic of influenza she devoted herself with complete abnegation to the sick at the Military Hospital at Sens, and cared for them with the greatest skill and devotion.

"Dr. Eva C. Reid is authorized to wear this medal suspended by a ribbon of the tricolors, equally divided. This certificate is given her to perpetuate in her family and among her fellow citizens a souvenir of her honorable and courageous conduct.

"Paris, January 14, 1919."

CHARLES B. REITZ

Medical Corps, U. S. Army

June 24, 1917-January 2, 1919

1st Lieutenant-Major

M. O. T. C., Fort Benjamin Harrison, Indiana; Rockefeller Institute, New York City; Base Hospital, Camp Sheridan, Alabama; Instructor to medical officers; Sanitary Service and mustering, M. O. T. C., Fort Riley, Kansas; Psychiatry; Ward Surgeon; Mustering Officer, Sanitary Inspector; Medical Officer, Troop trains; Laboratory, Base Hospital, Fort Riley, Kansas; examiner, boards for army promotions.

Major, M. R. C.

JOHN HENRY WALLACE RHEIN

Medical Corps, U. S. Army

July 30, 1917-February 8, 1919

Major

Neuropsychiatric service: Charge, Neuropsychiatric Examinations, Pennsylvania National Guard; Charge, Neuropsychiatric Examinations, served on Board, and Chief of Neuropsychiatric Service, 90th Division, Camp Travis, Texas.

A. E. F., England and France, February 8, 1918-January 26, 1919: Attached to B. E. F., London General Hospital No. 4, England (February 8-April 19, 1918); Consultant in Neuropsychiatry, Neufchateau, France, Second Army, Toul, France, and Base Section No. 5, Brest, France; Commanding Officer, Army Neurological Hospital No. 2, Toul, and No. 1, Benoitevaux, France.

THOMAS J. RIACH

Medical Corps, U. S. Army

August 30, 1917-December 15, 1919

1st Lieutenant-Major

Neuropsychiatric service: Division Psychiatrist, 33d Division; Camp Logan, Texas.

A. E. F., France, May 23, 1918-May 14, 1919: Division Psychiatrist and Assistant Division Surgeon, 33d Division. Demobilization Board, Camp Grant, Illinois; U. S. A. General Hospital No. 43, Hampton, Virginia.

ROBERT LEWIS RICHARDS

Medical Corps, U. S. Army

October 1, 1917-

Contract Surgeon-

Neuropsychiatric service: Special details, Office of the Surgeon General, Washington, D. C.: Supervising installation of Neuropsychiatric Boards on Pacific Coast; Military Director of hospital designated by the Secretary of War for cases on or near Pacific Coast.

WILLIAM WADDLE RICHARDSON

Chairman, Mercer Branch, Mercer County (Pennsylvania) Chapter, American Red Cross, May-December, 1917.

Medical Corps, U. S. Army

December 14, 1917-March 12, 1919

Captain-Major

Neuropsychiatric service: Philadelphia General Hospital, Philadelphia, Pennsylvania; Neuropsychiatric Boards, Camp Beauregard, Louisiana, Camp Doniphan, Oklahoma, and Camp Dodge, Iowa; Port of Embarkation.

A. E. F., France, June 28, 1918–February 9, 1919: Consultant, in Neuropsychiatry, Base Hospital Center, Nantes; Base Hospital No. 11, Nantes.

U. S. A. General Hospital No. 30, Plattsburg, New York; Camp Custer, Michigan.

CHARLES RICKSHER

Medical Corps, U. S. Army

October 14, 1917–February 22, 1919

Captain

Neuropsychiatric service: O. T. C., Fort Sheridan, Alabama; Camp Joseph E. Johnston, Florida.

A. E. F., France, July 15, 1918–February 19, 1919: 1st Depot Division; Rimaucourt Hospital Center; Base Hospital No. 7, Joue-le-Tours.

C. EUGENE RIGGS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Minnesota of the American Medico-Psychological Association.

ARTHUR H. RING

Medical Corps, U. S. Army

October 28, 1918–June 17, 1919

Captain

Neuropsychiatric service: U. S. A. General Hospital No. 28, Fort Sheridan, Illinois.

ROMNEY MOORE RITCHEY

Medical Corps, U. S. Army

December 13, 1917–October 10, 1919

Captain-Major

Neuropsychiatric service: Philadelphia General Hospital, Philadelphia, Pennsylvania; Member, Neuropsychiatric Board, Kelly Field, El Paso District and Camp McArthur, Texas, and Camp Cody, New Mexico; Division Psychiatrist, Camp Funston, Kansas.

A. E. F., France, June 15, 1918–February 11, 1919: Division Psychiatrist, 92d Division.

U. S. A. General Hospital No. 38, East View, New York; Base Hospital, Camp Lewis, Washington, and Base Hospital, Fort Bliss, Texas.

Major, M. R. C.

G. WILSE ROBINSON

Medical Corps, U. S. Army

February 26, 1918–February 1, 1919

Captain-Major

Neuropsychiatric service: Fort McPherson, Georgia.

A. E. F., France, June 1, 1918–January 30, 1919: Base Hospital No. 28, Limoges.

LEIGH F. ROBINSON

Medical Corps, U. S. Marine Corps

May 8, 1917-

Lieutenant (j. g.)-Lieutenant-

Naval Medical School

Marine expeditionary duty, Santo Domingo, West Indies, June 13, 1917-; Second Brigade Marines; Chief Sanitary Officer of the provinces of Santiago and La Vega.

AARON J. ROSANOFF

Medical Corps, U. S. Army

September 1, 1917-March 31, 1919

Captain-Major

Neuropsychiatric service: Camp Psychiatrist and, also, Chief of Neuropsychiatric service, Base Hospital, Camp Upton, New York; U. S. A. General Hospital No. 30, Plattsburg, New York.

Lt. Colonel, M. R. C.

CHARLES E. ROSS

Medical Corps, U. S. Army

September 12, 1918-March 8, 1919

Captain

Neuropsychiatric service: Special Boards, Fort Des Moines, Iowa; Camp Custer, Michigan; and Camp Greenleaf, Georgia.

DONALD L. ROSS

Medical Corps, U. S. Army

October 15, 1918-April 6, 1919

Major

Neuropsychiatric service: Walter Reed General Hospital, Washington, D. C.; Port of Embarkation, Newport News, Virginia; U. S. A. General Hospital No. 13, Dansville, New York.

GEORGE A. ROWLAND

Medical Corps, U. S. Army

June 26, 1918-

Lieutenant-

Neuropsychiatric service: Camp Lee, Virginia; U. S. A. General Hospital No. 13, Dansville, New York.

CHARLES C. ROWLEY

Medical Corps, U. S. Army

August 11, 1917-

Lieutenant-Captain-

Neuropsychiatric service: Fort Riley, Kansas; Boston Psychopathic Hospital, Boston, Massachusetts; New York Neurological Institute, New York City; Camp Devens, Massachusetts; Camp Meade, Maryland; Camp Stuart, Virginia; Office of Port Surgeon, Port of Embarkation, Newport News, Virginia.

ARTHUR H. RUGGLES

Medical Corps, U. S. Army

July 20, 1917-March 21, 1919

Major

Neuropsychiatric service, A. E. F., England and France, August 13, 1917-March 6, 1919: Craiglockhart War Hospital, London; Division Psychiatrist, 2d Division; Medical Director, Base Hospital No. 214, Savenay, France.

WILLIAM L. RUSSELL

Member, Committee on War Work, American Medico-Psychological Association.

Member, Executive Committee of the War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Smith College Training School for Psychiatric Social Work, Subcommittee on Classification of Institutions for Nervous and Mental Disorders, Subcommittee on Reëducation.

EDWARD RYAN

Medical Corps, Canadian Army

2 years

Captain

Neuropsychiatric service: Director, Medical Service, D. and F. Units, Soldiers Civil Reëtablissement, Toronto, Canada; M. O. D. Unit M. H. C., Ontario Military Hospital, Orpington, Kent, Toronto.

BERNARD SACHS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

THOMAS W. SALMON

Study of the care and treatment of war neuroses ("shell-shock") cases, British military hospitals, at the request of the Surgeon General of the U. S. Army, May-June, 1917.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees for the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Reëducation.

Medical Corps, U. S. Army

October 1, 1917-May 5, 1919

Major-Colonel

Neuropsychiatric service: Assistant, Division of Neurology and Psychiatry, Office of the Surgeon General, Washington, D. C.

A. E. F., December 1, 1917-March 6, 1919: Senior Consultant in Neuropsychiatry.

Distinguished Service Medal.

Colonel, M. R. C.

CHARLES F. SANBORN

Medical Corps, U. S. Army

August 14, 1917-

Captain-

State Psychopathic Hospital, Ann Arbor, Michigan, August 14, 1917.

Captain, M. R. C.

WILLIAM C. SANDY

Medical Corps, U. S. Army

July 23, 1918-May 3, 1919

Lieutenant-Captain

Neuropsychiatric service: Camp Devens, Massachusetts; Division of Neurology and Psychiatry, Office of the Surgeon General, Washington, D. C.

Major, M. R. C.

GEORGE F. SARGENT

Local and advisory draft boards, Maryland.

Medical Corps, U. S. Army

August, 1918-June 13, 1919

Captain-Major

Neuropsychiatric service: Head of Neuropsychiatric Board, Camp Meade, Maryland.

CARL W. SAWYER

Medical Corps, U. S. Army

August 15, 1918-January 28, 1919

1st Lieutenant

Neuropsychiatric service: Camp Shelby, Mississippi; Camp Meade, Maryland.

JOHN MILTON SCANLAND

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Montana of the American Medico-Psychological Association.

Medical Advisory Board, Deer Lodge County, Montana (lectures to draft men).

Medical Corps, U. S. Army

April, 1918-January, 1919

Captain

Neuropsychiatric service: Base Hospital, Camp Lewis, Washington.

WALTER ARTHUR SCHMITZ

Medical Corps, U. S. Army

July 26-December 11, 1918

1st Lieutenant

Neuropsychiatric service: Examining Board and Base Hospital, Camp Upton, New York.

GUTHRIE EUGENE SCRUTCHFIELD

Medical Corps, U. S. Army

October 16, 1917-September 6, 1919

Captain-Major

Neuropsychiatric service: Walter Reed General Hospital, Washington, D. C.; Camp Stuart, Virginia; U. S. A. General Hospital No. 37, Madison Barracks, New York; U. S. A. General Hospital No. 30, Plattsburg, New York; Attending Surgeon's Office, New York City.

JAMES T. SEARCY

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Alabama of the American Medico-Psychological Association.

Deceased, April 6, 1920

WILLIAM ALONZO SEARL

Medical Corps, U. S. Army

September, 1917-July, 1919

Captain-Major

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.; U. S. A. General Hospital No. 1, Williamsbridge, New York; Consulting Psychiatrist, Army Medical School, Washington, D. C.
Lt. Colonel, M. R. C.

HARRY S. SEIWELL

Medical Corps, U. S. Army
October 4, 1917-June 30, 1919
1st Lieutenant-Captain

M. O. T. C.; Convalescent Camp No. 2.

A. E. F., France, May 22, 1918-May 1, 1919: Convalescent Camp No. 2.

Major, M. R. C.

EDWARD AFFLECK SHARP

Medical Corps, U. S. Army
June 30, 1918-July 7, 1919
Captain-Major

Neuropsychiatric service: Neuropsychiatric Board, Camp Crane, Pennsylvania.

A. E. F., France, September 13, 1918-: Base Hospital No. 78, Toul; Army Neurological Hospital No. 2, Toul; Army Neurological Hospital No. 3, Neubecourt; Evacuation Hospital No. 1, Sevastapool, Crimea; Base Hospital No. 65, Kerhuon, France; Camp Hospital No. 33.

GEORGE A. SHARP

Medical Corps, U. S. Army
December 6, 1917-July 8, 1919
Captain

Neuropsychiatric service: New York Neurological Institute, New York City; Neurological Boards, Camp Mills, New York, Camp Devens, Massachusetts, and Camp Upton, New York.

A. E. F., September 15, 1918-July 1, 1919: Division Psychiatrist, 1st Division.

ARTHUR L. SHAW

Member, Medical Examining Board, Livingston County, New York.

Medical Corps, U. S. Army
March 12-May 19, 1918
Contract Surgeon

Neuropsychiatric service: Inspecting hospital sites for proposed epileptic colonies, and other work in regard to the problem of epilepsy. Instructor, Military Neuropsychiatric School, New York Neurological Institute, New York City.

ROBERT F. SHEEHAN

Medical Corps, U. S. Navy (Regular)
Lieutenant Commander

Psychiatrist, 3d Naval District; Consulting Neuropsychiatrist, U. S. Public Health Service Hospital, New York City.

Sea duty, February-July, 1918: Medical Officer U. S. S. San Diego (cruiser in charge of convoys from Halifax, Nova Scotia, to rendezvous off north coast of Ireland).

Consultant to Neurologist, U. S. Naval Hospital, Brooklyn, New York.

H. B. SIGHTS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Kentucky of the American Medico-Psychological Association.

JOHN CRAYKE SIMPSON

Medical Advisory Boards No. 3 and No. 4, Washington, D. C., duration of war.

H. DOUGLAS SINGER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

JOSEPH SLATTERY

Medical Corps, U. S. Army

September 6-13, 1918

Contract Surgeon

Neuropsychiatric service: Camp Sherman, Ohio.

ROCK SLEYSTER

Secretary, Medical Section, State Council of Defense, Wisconsin.

Charge of medical work, Wisconsin draft boards.

Examining Surgeon for M. R. C.

Medical Corps, U. S. Army

November 15, 1917-January 4, 1919

1st Lieutenant-Major

Assigned as medical aide to the Governor of Wisconsin, working under orders of the Provost Marshal General.

H. MASON SMITH

Medical Corps, U. S. Army

July 20, 1918-March 8, 1919

1st Lieutenant

Neuropsychiatric service: New York Neurological Institute, New York City; U. S. A. General Hospital No. 22, Richmond, Virginia; U. S. A. Debarkation Hospital No. 52.

HENRY G. SMITH

Medical Corps, U. S. Army

July 12, 1917-July 5, 1919

1st Lieutenant-Captain

Surgical service: Mayo Clinic, Rochester, Minnesota; Base Hospital, Camp Sheridan, Alabama.

A. E. F., France, 1 year: Base Hospital No. 19, Vichy; Motor Reception Prk, Marseille (administrative).

ROBERT PERCY SMITH

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Washington of the American Medico-Psychological Association.

Medical Corps, U. S. Army

August 28, 1917-

1st Lieutenant-Major-

Neuropsychiatric service: Chief of Neuropsychiatric Service, Base Hospital, Camp Lewis, Washington; Division Psychiatrist, 91st Division, and President of Neuropsychiatric Board, Camp Headquarters, Camp Lewis, Washington.

A. E. F., France and Belgium, June 20, 1918-January, 1919: Division Psychiatrist, 91st Division; Base Hospital No. 214, Savenay, France.

Camp Psychiatrist, Camp Lewis, Washington; Neuropsychiatrist. Fort Logan, Colorado (physical muster in recruiting depot).

S. E. SMITH

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Indiana of the American Medico-Psychological Association.

EARL H. SNAVELY

Draft Board, New Jersey
Instructor, first aid classes.

Medical Corps, U. S. Army
October 10, 1918–February 5, 1919
1st Lieutenant

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.;
Camp Hospital, Camp Abraham Eustis, Virginia.

CHARLES H. SOLIER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Wyoming of the American Medico-Psychological Association.

HARRY C. SOLOMON

Contract Surgeon, Medical Corps, U. S. Army.
Instructor, Military Neuropsychiatric Training School, Boston Psychopathic Hospital, Boston, Massachusetts, November, 1917–March, 1918.

Medical Corps, U. S. Army
March 10, 1918–May 6, 1919
1st Lieutenant

Neurosurgical service: U. S. A. General Hospital No. 11, Cape May, New Jersey; Base Hospital No. 115.

A. E. F., France, August 15, 1918–April 15, 1919: Base Hospital No. 115, Vichy; Base Hospital No. 214, Savenay.

ELBERT M. SOMERS

Draft Board, New York

Medical Corps, U. S. Army
October 4, 1918–April, 1919
Captain–Major

American Red Cross, France, 6 months: Superintendent, Base Hospital No. 1, Neuilly.

WILLIAM G. SOMERVILLE

Medical Corps, U. S. Army
August 2, 1917–March 1, 1919
Captain–Lt. Colonel

Neuropsychiatric service: U. S. A. General Hospital No. 14, Fort Oglethorpe, Georgia.

A. E. F., France, August 22, 1918–February 22, 1919: Base Hospital No. 61, Beaune.

ARTHUR E. SOPER

Medical Corps, U. S. Army
October 9, 1918–September 19, 1919
Captain

Neuropsychiatric service: St. Elizabeths Hospital, Washington, D. C.;
U. S. A. General Hospital No. 37, Madison Barracks, New York;
Port of Debarkation, Newport News, Virginia.

ELMER ERNEST SOUTHARD

Acting Chairman, Committee on Neurology and Psychiatry, National Research Council, 1918.

Member, Boston Committee on Occupational Therapy, 1918.

Member, Executive Committee of the War Work Committee, The National Committee for Mental Hygiene, New York City; Chairman, Subcommittee on Smith College Training School for Psychiatric Social Work, and member, Subcommittee on Clinical Methods and Subcommittee on Classification of Hospitals, of the War Work Committee.

Medical Corps, U. S. Army

November 2, 1917–April 6, 1918

Contract Surgeon

Neuropsychiatric service: Director, Military Neuropsychiatric Training School, Boston Psychopathic Hospital, Boston, Massachusetts.

Chemical Warfare Service, U. S. Army

September 14–November 21, 1918

Major

Officer of the Chief, Chemical Warfare Service, Washington, D. C.

Deceased, February 8, 1920

HARRY O. SPALDING

Member and Chairman, Medical Advisory Board No. 18, Massachusetts, from time of organization, February, 1918.

IRVING J. SPEAR

Medical Advisory Board, Baltimore, Maryland.

Medical Corps, U. S. Army

October 1, 1918–September 16, 1919

Captain–Major

Neuropsychiatric service: U. S. A. General Hospital No. 6, Fort McPherson, Georgia.

DWIGHT S. SPELLMAN

Medical Corps, U. S. Army

October 5–December 4, 1918

Captain

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York; Camp Crane, Pennsylvania.

Deceased, December 18, 1919

A. WARREN STEARNS

Medical Corps, U. S. Naval Reserve Force

July 21, 1917–April 1, 1919

Lieutenant (j. g.)–Lieutenant

Neuropsychiatric service: 12th Naval District, San Francisco, California.

HARRY A. STECKEL

Medical Corps, U. S. Army

June 14, 1917–April 29, 1919

1st Lieutenant–Captain

General Medical Officer, M. O. T. C., Fort Benjamin Harrison, Indiana.

A. E. F., August 9, 1917–April 4, 1919: Civil Population Service, American Red Cross; Division Psychiatrist, 26th Division.

HENRY R. STEDMAN

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Massachusetts of the American Medico-Psychological Association.

HENRY LOUIS STICK

Medical Corps, U. S. Army

April, 1917-

Captain-

Neuropsychiatric service: Camp Psychiatrist, Fort Benjamin Harrison, Indiana; Chief of Neuropsychiatric Service, Base Hospital, Camp Sherman, Ohio; Camp Psychiatrist, Camp Sheridan, Alabama; Demobilization Board, Camp Greene, North Carolina; U. S. A. General Hospital No. 30, Plattsburg, New York.

EDWARD A. STRECKER

Medical Corps, U. S. Army

August 4, 1917-April 9, 1919

1st Lieutenant-Major

Neuropsychiatric service: Chief of Neuropsychiatric Service, Base Hospital, Camp Hancock, Georgia; Division Psychiatrist, 28th Division.

A. E. F., France, June 1, 1918-March, 1919: Division Psychiatrist, 28th Division.

KARL B. STURGIS

Medical Corps, U. S. Army

October 26, 1918-June 24, 1919

1st Lieutenant

Neuropsychiatric service: U. S. A. General Hospital No. 34, East Norfolk, Massachusetts.

FRANCIS J. SULLIVAN

Medical Corps, U. S. Army

October 28, 1918-

Captain-

Neuropsychiatric service: Camp McClellan, Alabama; Camp Meade, Maryland.

HENRY M. SWIFT

Medical Corps, U. S. Army

July 28, 1917-July 25, 1919

Captain-Major

Neuropsychiatric service: El Paso, Texas; Southern Department.

A. E. F., England and France, 17 months: Maudsley, 4th London General Hospital, England; B. E. F., 77th Field Artillery; Base Hospitals No. 8 and No. 214, Savenay, France.

HERBERT W. TAYLOR

Medical Corps, U. S. Army

March 28, 1917-

1st Lieutenant-Major-

Neuropsychiatric service: 26th Division.

A. E. F., France, October 2, 1917-April 18, 1919: 1st and 26th Divisions; Commanding Field Hospital; Regimental Surgeon; 1st Corps Schools, Gondricourt; Command, Ambulance Section (4 companies), 26th Division.

Charge, Medical Service, Camp Devens, Massachusetts.

ISAAC M. TAYLOR

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from North Carolina of the American Medico-Psychological Association.

MELVIN J. TAYLOR

Medical Corps, U. S. Army

April 19, 1918-April 23, 1919

1st Lieutenant

Neuropsychiatric service: 79th Division, Camp Meade, Maryland.

A. E. F., France, July, 1918-February, 1919: Base Hospital No. 117, Lafauche.

FRED W. TERFLINGER

Medical Advisory Board, Cass County, Indiana.

Medical Corps, U. S. Army

September 5, 1918-February 11, 1919

Captain

Neuropsychiatric service: Camp Sherman, Ohio; Base Hospital and Neuropsychiatric Board, Camp Lee, Virginia; U. S. A. General Hospital No. 25, Fort Benjamin Harrison, Indiana.

WILLIAM B. TERHUNE.

Medical Corps, U. S. Army

May 9, 1917-May 21, 1919

1st Lieutenant

Neurosurgical service: U. S. A. General Hospital No. 2, Fort McHenry, Maryland.

A. E. F., France, 21 months: B. E. F., 1 year; Base Hospital No. 5; American Red Cross Military Hospital, Paris.

DOUGLAS A. THOM

Medical Corps, U. S. Army

August 20, 1917-March 26, 1919

Captain

Neuropsychiatric service: Camp Devens, Massachusetts.

A. E. F., England and France, 13 months: Maudsley Neurological Clearing Hospital, London; Maghull Military Hospital, Liverpool; Base Hospital No. 117, Lafauche, France.

CHARLES W. THOMPSON

Member, Medical Advisory Board No. 1, Colorado, December 1, 1917-March 1, 1919. Neuropsychiatric examinations.

FREDERIC H. THORNE

Medical Corps, U. S. Army

June 15, 1917-

1st Lieutenant-

Base Hospitals and laboratories (bacteriology and pathology).

A. E. F., 10 months, Commanding 6th Field Laboratory, 6th Division.

A. A. THURLOW

Medical Corps, U. S. Army

September, 1918-July 12, 1919

1st Lieutenant

Neuropsychiatric service: Camp Funston, Kansas; Kelly Field, Texas.

JOSEPH H. TOOMEY

Medical Corps, U. S. Army

June 5, 1918-

1st Lieutenant-

Neuropsychiatric service: Camp Surgeon's Office, Camp Lee, Virginia;
U. S. A. Disciplinary Barracks, Fort Jay, New York; Post Hospital, Fort Slocum, New York.

THEODORE I. TOWNSEND

Medical Advisory Board, Binghamton, New York, December 10, 1917-
August 16, 1918.

Medical Corps, U. S. Army

August 16, 1918-April 25, 1919

Captain

Neuropsychiatric service: Camp Meade, Maryland; U. S. A. Debarkation Hospital No. 51, Hampton, Virginia.

JOHN HENRY TRAVIS

Medical Corps, Canadian Army

November 7, 1918-August 31, 1919

Captain

Neuropsychiatric service: Neurological Hospital, Toronto, Canada.

L. E. TRENT

Medical Corps, U. S. Army

October 18, 1918-February 9, 1919

1st Lieutenant

Neuropsychiatric service: Camp Taylor, Kentucky.

A. E. F., France, November 15, 1918-February 7, 1919: Base Hospital No. 214, Savenay.

NELSON G. TRUEMAN

Medical Corps, U. S. Army

November 5, 1918-March 22, 1919

Captain

Neuropsychiatric service: Examining Board and Base Hospital, Camp Humphreys, Virginia.

RALPH P. TRUITT

Medical Corps, U. S. Army

May 10, 1917-May 8, 1919

Lieutenant-Major

Neuropsychiatric service: R. O. T. C., Princeton, New Jersey; Camp Psychiatrist, Camp Funston, Kansas; instructor and in charge of neuropsychiatric work, M. O. T. C., Fort Riley, Kansas, and Fort Snelling, Minnesota; In charge of Department of Psychiatry and Sociology, U. S. A. Disciplinary Barracks, and Consulting Neuropsychiatrist, U. S. Penitentiary, Fort Leavenworth, Kansas.

BEVERLEY R. TUCKER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City.

Medical Advisory Board, Richmond, Virginia, 1 year.

Medical Corps, U. S. Army

August 1-September 15, 1918

Contract Surgeon

Neuropsychiatric service: Camp Lee, Virginia.

JOHN SHADE TURNER

Member, National Council of Defense, Medical Section, Texas.
Neurologist, 18th District Advisory Board, Dallas, Texas.

Medical Corps, U. S. Army

October 18, 1918–February 14, 1919

Captain

Neuropsychiatric service: Camp Travis, Texas.

REEVE TURNER

Medical Corps, U. S. Army

June 15, 1917–

Captain–

Neuropsychiatric service: Fort Benjamin Harrison, Indiana; State Psychopathic Hospital, Ann Arbor, Michigan; Camp Sherman, Ohio.

A. E. F., France, September 1, 1918–: Base Hospital No. 77, Beaune; Camp Hospital No. 107.

FORREST C. TYSON

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Maine of the American Medico-Psychological Association.

CHARLES L. VAUX

Medical Corps, U. S. Army

July 1, 1918–April 3, 1919

Captain

Neuropsychiatric service: Base Hospital, Camp Wheeler, Georgia; U. S. A. General Hospital No. 30, Plattsburg, New York.

A. E. F., France, 5 months: Base Hospital No. 117, Lafauche; Division Psychiatrist, 40th Division.

WILLARD H. VEEDER

Medical Corps, U. S. Army

October 9, 1918–May 1, 1919

Captain

Yale Army Laboratory, New Haven, Connecticut; U. S. A. General Hospital No. 3, Colonia, New Jersey; Army Medical Museum, Washington, D. C.

FULTON SCHUYLER VROOMAN

Medical Corps, Canadian Army

November, 1916–July, 1919

Lieutenant–Captain

Work with mental and psychoneurotic patients, Canada.

Canadian General Hospital No. 15, Taplow, England (gas poisoning).

CHARLES G. WAGNER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from New York of the American Medico-Psychological Association.

DREW M. WARDNER

Medical Corps, U. S. Army

September 10, 1917–

Lieutenant–

Neuropsychiatric service: Base Hospital, Fort Logan, Colorado.

PAUL WATERMAN

Medical Corps, U. S. Army

October 8, 1917–August 26, 1919

Major-Colonel

A. E. F., October 8, 1917–March 25, 1919: Director of Ambulance Company; Commander of Sanitary Train; Division Surgeon, 4th Division.

Colonel, M. R. C.

THEODORE H. WEISENBURG

Member, Executive Committee of the War Work Committee, The National Committee for Mental Hygiene, New York City; member of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Neuropsychiatric Instruction, Subcommittee on Reëducation.

Contract Surgeon, Medical Corps, U. S. Army, September 17, 1917–September 24, 1918: Director, Military Neuropsychiatric Training School, Philadelphia General Hospital, Philadelphia, Pennsylvania.

Editor-in-Chief, "Manual of Neurosurgery," Office of the Surgeon General, Washington, D. C.

Medical Corps, U. S. Army

September 24, 1918–March 25, 1919

Major

Neuropsychiatric service: Chief of Clinic, U. S. A. General Hospital No. 30, Plattsburg, New York; Chief of Neurological Service (neurosurgical), U. S. A. General Hospital No. 1, Williamsbridge, New York.

ANNA C. WELLINGTON

Medical Service, American Red Cross, France

May 1, 1918–January 28, 1920

Civilian Refugee Dispensary. Triage, Gare de la Chapelle, Paris.

JULIUS FERMAN WENN

Medical Corps, U. S. Army

August 30–December 28, 1918

Captain

Neuropsychiatric service: Camp Grant, Illinois; Camp Sherman, Ohio; U. S. A. General Hospital No. 30, Plattsburg, New York.

ADELINE MAY WESCOTT

Medical Service, American Red Cross, Bureau of Tuberculosis, France.

April 3, 1918–May 1, 1919

Dispensary, home and sanitation among the French civilians.

WILLIAM A. WHITE

Director, Military Neuropsychiatric Training School, St. Elizabeths Hospital, Washington, D. C.

Member, Committee on War Work, American Medico-Psychological Association.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the subcommittee on Clinical Methods and of the Subcommittee on Classification of Hospitals, of the War Work Committee; also, representative from the District of Columbia of the American Medico-Psychological Association.

BENJAMIN OTIS WHITTEN

Medical Corps, U. S. Army

1st Lieutenant

Order to active duty revoked and advised to remain in institutional work.

CORNELIUS COLLINS WHOLEY

Medical Corps, U. S. Army

November 11, 1918-April 22, 1919

Captain

Neuropsychiatric service: U. S. A. General Hospital No. 30, Plattsburg, New York; U. S. A. General Hospital No. 7, Roland Park, Maryland.

OTTO G. WIEDMAN

Medical Corps, U. S. Army

September 7, 1917-August 6, 1919

Captain-Major

Neuropsychiatric service: Boston Psychopathic Hospital, Boston, Massachusetts; New York Neurological Institute, New York City; Division Psychiatrist, 38th Division; Neuropsychiatrist, Base Hospital, Camp Bowie, Texas.

A. E. F., October 21, 1918-July 24, 1919: Division Psychiatrist, 4th and 38th Divisions; Camp Hospital No. 90, Commercy, France; Base Hospitals No. 25, No. 49, and No. 97, Allerey, France; Base Hospital No. 117, Lafauche.

SIDNEY D. WILGUS

Psychiatrist, Medical Advisory Board, Rockford, Illinois.

Medical Corps, U. S. Army

November 5-19, 1919

Contract Surgeon

Neuropsychiatric service: Hospital inspection, St. Louis, Missouri.

BENJAMIN FRANKLIN WILLIAMS

Local Draft Board No. 1, Lincoln, Nebraska.

Contract Surgeon, Medical Corps, U. S. Army, August 4-October, 1917.

Medical Corps, U. S. Army

October 23, 1918-July 15, 1919

Captain-Major

Neuropsychiatric service: Camp McArthur, Texas; Camp Gordon, Georgia.

C. F. WILLIAMS

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from South Carolina of the American Medico-Psychological Association.

FRANKWOOD E. WILLIAMS

Member, Committee on War Work, American Medico-Psychological Association.

Vice-chairman, War Work Committee, The National Committee for Mental Hygiene, New York City; member of the Executive Committee and of the following subcommittees of the War Work Committee: Subcommittee on Clinical Methods, Subcommittee on Classification of Hospitals, Subcommittee on Classification of Institutions for Nervous and Mental Disorders, Subcommittee on Neuropsychiatric Instruction, Subcommittee on Reeducation, Subcommittee on Legislation.

Medical Corps, U. S. Army
June 1, 1918-March 15, 1919
Captain-Major

Neuropsychiatric service: First Assistant and Acting Chief, Division of Neurology and Psychiatry, Office of the Surgeon General, Washington, D. C.

Lt. Colonel, M. R. C.

GUY H. WILLIAMS

Draft Board No. 2, Columbus, Ohio, June-July, 1918

Medical Corps, U. S. Army

September, 1918

Contract Surgeon

Neuropsychiatric service: Camp Sherman, Ohio.

JOHN I. WISEMAN

Medical Corps, U. S. Army

June 9, 1917-March 6, 1919

1st Lieutenant-Captain

A. E. F., July 12, 1917-February 11, 1919: Maudsley Neurological Clearing Hospital, London; Field Ambulance and Battalion Medical Officer, 17th Division, B. E. F.; also, neuropsychiatric service, A. E. F.

GEORGE BANEY WOLFF

Member Local Draft Board No. 4, Baltimore Co., Md.; Member Medical Advisory Board No. 2, Baltimore, Md.

Deceased, December 21, 1918

ROBERT C. WOODMAN

Member, Medical Advisory Board No. 49, Newburgh, New York, and later No. 48, Middletown, New York, from organization until disbanded.

C. R. WOODSON

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Missouri of the American Medico-Psychological Association.

HUBERT WORK

Member, Local Board, also, Medical Advisory Board, Colorado, June, 1917-March, 1918.

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Colorado of the American Medico-Psychological Association.

Medical Corps, U. S. Army

March 22-December 12, 1918

Major-Colonel

Provost Marshal General's Office (Medical Supervisor of Draft), Washington, D. C.

Colonel, M. R. C.

PHILIP WORK

Medical Corps, U. S. Army

June 1, 1917-May 26, 1919

1st Lieutenant-Major

Neuropsychiatric service: Fort Riley, Kansas; Fort Douglas, Utah; Division Psychiatrist, Camp Dodge, Iowa.

A. E. F., September 1, 1918-: Psychiatrist, 88th Division.

Major, M. R. C.

HARRY J. WORTHING

Medical Corps, U. S. Army

September 30, 1917-

Captain-

Neuropsychiatric service: Division Psychiatrist, 27th Division, Camp Wadsworth, South Carolina; Camp Sevier, South Carolina.

A. E. F.: Division Psychiatrist, 27th Division.

HAROLD W. WRIGHT

Medical Corps, U. S. Army

May 29, 1917-June 12, 1919

Lieutenant-Captain

General and neuropsychiatric service: Fort Riley, Kansas; The Presidio, San Francisco, California; Camp Kearney, California; Letterman General Hospital, San Francisco, California.

A. E. F., France, May 4, 1918-February 16, 1919: Ambulance Neurologique, Neubecourt; Special Boards, Base Hospital No. 30, Royat; Base Hospital No. 117, Lafauche; 77th Division.

A. R. T. WYLIE

Member, Local Board, Walsh County, North Dakota, July 31, 1917-March 31, 1919. Medical examinations.

Chairman, Grafton (North Dakota) Branch, American Red Cross, June 6, 1917-July 10, 1918.

E. H. YOUNG

Medical Corps, Canadian Army

May 12, 1916-

Captain-Major-

Neuropsychiatric service: Granville Canadian Special Hospital; Canadian General Hospital No. 4; Canadian Stationary Hospital No. 10, Calais; Cobourg Special Hospital for Mental Diseases.

C. E. F., August 4, 1916-May 20, 1918: Officer commanding special hospital for mental cases.

HUGH H. YOUNG

Medical Corps, U. S. Army

May 25, 1917-January 28, 1919

Major-Colonel

A. E. F., France, June 8, 1917-January 14, 1919: Senior Consultant, Urology and Dermatology, Neuchateau.

Colonel, M. R. C.

LORNE W. YULE

Medical Corps, U. S. Army

September 6-28, 1918

Contract Surgeon

Neuropsychiatric service: 160th Depot Brigade, Camp Custer, Michigan.

GEORGE A. ZELLER

Member, War Work Committee, The National Committee for Mental Hygiene, New York City, representative from Illinois of the American Medico-Psychological Association.

MEMORIAL NOTICES.

EDWARD COWLES, M. D.

Edward Cowles was born in Ryegate, Vt., July 20, 1837, and died in Plymouth, Mass., July 25, 1919, at the advanced age of 82 years and five days. He was graduated from Dartmouth College in 1859 and in medicine from Dartmouth and the College of Physicians and Surgeons (N. Y.) in 1863. He also received the degree of LL. D. from Dartmouth in 1890. He was an assistant physician in the Hartford Retreat for a few months and then entered the medical service of the U. S. Army from which he retired in 1872 with the rank of captain. After a short period of practice in Boston he became superintendent of the Boston City Hospital which position he held till 1879 when he was elected medical superintendent of the McLean Asylum for the Insane, then located in Somerville. He retired December 31, 1903, after twenty-four years of distinguished service.

This in brief is the outline of his life, but it tells little of the man and his achievements. As a medical officer in the army he acquired a knowledge and experience which with further development made him an authority in hospital construction and management. During his seven years of service he planned and erected four important buildings and revolutionized the administration of the Boston City Hospital. While there he rendered a service to the cause of the education of nurses in general hospitals which few now appreciate. When he went to the City Hospital, four training schools for nurses had been established in this country, all of which, while connected with hospitals in the way of giving nursing service, were independently organized and were maintained by private benevolence. Money from private sources was not available for a school at the City Hospital and Dr. Cowles in 1878 persuaded the trustees to open one as a department of the hospital and finance it from hospital funds. It was the first school so established and the example has been almost universally

followed. Had the world been obliged to await private benefaction there even now would be few schools and these chiefly in large cities and in connection with important hospitals.

Dr. Cowles' preparation for the superintendency of a hospital for mental diseases, aside from his experience as a hospital administrator, was somewhat slender, consisting of a short service in the Hartford Retreat and an inspection of hospitals in England, Scotland and France during the summer of 1879. It is therefore not surprising that the wisdom of his selection was questioned by men old in the service when he went to McLean.

His administration there was dominated by the central idea of making a hospital of the asylum and of keeping the custodial element as far as possible in the background. To this end he began in an experimental way, with an eye to the new hospital soon to be built at Waverley, an extensive renovation of the old buildings at Somerville, the removal of some of the guards to windows and the unlocking of some of the doors. He freely used the law for the voluntary admission of patients, the passage of which he had advocated, encouraged frequent visits of relatives and friends to patients at all stages of their illness, and visits to their homes by the convalescent. He fitted up primitive gymnasiums, established a training school for the nurses—the first formally organized school in a hospital for mental diseases in the world, employed women nurses in the men's wards, and ward-maids to relieve the nurses of some of the drudgery of their work. He introduced the custom of employing internes as in general hospitals, otherwise increased the medical staff, established laboratories for research, began the collection of a large and valuable medical library, and changed the name from asylum to hospital. We now expect as a matter of course to find all these things in any good hospital for mental diseases but most of them were radical departures from the custom of that day.

With the experience gained at Somerville, added to his former exceptional knowledge of hospital construction, Dr. Cowles was eminently fitted to plan the new hospital at Waverley. The houses there were designed and were located primarily in the interest of the patients, with a view to the best known methods for their care and treatment as well as for their comfort, rather than with respect to ease and economy of administration. As a result there was

for several years a financial deficit, but the far-seeing plans of Dr. Cowles were long ago justified and it is largely because of them that the hospital is now self-supporting. The new McLean is his monument.

Dr. Cowles published many papers on the construction and management of hospitals both general and special, on the training of nurses for mental cases, on the different forms of mental disease and on allied subjects. He was professor of psychiatry at Dartmouth, instructor in mental diseases in the Harvard Medical School and a lecturer at Clark University, which position he held till he was 80 years of age. He was also a trustee of Clark University and of the Foxboro' State Hospital.

Personally, he was a man of courtly manners, kindly, considerate, always ready to listen to the suggestions of his subordinates, but he was a firm believer in discipline and the necessity for a centralization of authority. He was a genial companion, a wise counsellor and a faithful friend. During the later years of his life he suffered patiently from a failure of hearing and of eyesight and from occasional attacks of angina with one of which his last illness began.

By his death the American Medico-Psychological Association has sustained the loss of a distinguished member, who contributed largely to the construction and management of hospitals, the improvement of hospitals for mental diseases and the advancement of psychiatry in America.

GEORGE T. TUTTLE.

ERNEST ELMER SOUTHARD, M. D.

Dr. E. E. Southard was born in South Boston, Massachusetts, July 28, 1876, and died in New York City of pneumonia, February 8, 1920. His death was a distinct shock to his friends suddenly bereft of his stimulating presence, and in no circle will his loss be more keenly felt than in this Association of which he was president during the year 1918-1919.

Dr. Southard received the greater part of his education in Boston. He was Franklin Medalist at the Latin School in 1893; A. B., Harvard University 1897; M. D., Harvard Medical School 1901; A. M., Harvard University 1902; Sc. D., Honorary, George Washington University 1917.

After graduation in 1901 he was given an opportunity at the Boston City Hospital under Councilman and Mallory in pathology. In that year he published his first article, "A Case of Glioma of the Frontal Lobe," thus early indicating the trend of interest which throughout his career never wavered from the nervous system, its functions and structure.

Following this appointment he went abroad and came under the influence of Weigert, Nissl and Kraepelin. He often spoke of Weigert as being the greatest inspiration to him. From 1903 to 1906 he continued to work with Brinckerhoff at the Boston City Hospital in pathology, when he was appointed Pathologist at Danvers State Hospital. The same year he married and spent the following summer abroad.

Early in his Danvers period an enthusiastic group of workers collected about him. Whether the rich material at hand or the keen minds of his associates was the greater stimulus to his original psychiatric contributions, it is difficult to say, but his interest in that laboratory continued long after he was appointed Pathologist to the State Board of Insanity (1909), and he returned again and again to collect material and data.

In 1909 he became Pathologist to the Board of Insanity for the State, and at the same time was promoted to the Bullard Pro-

fessorship of Neuropathology at the Harvard Medical School—a full professor at 33 years!

In 1911 he received a virulent infection of his left hand from an autopsy and was very ill. In the summer he went abroad to recuperate. He spoke of that as his “unproductive year,” having published nothing, but he was getting ready for his new work as director of the Psychopathic Department of the Boston State Hospital. This hospital opened in June, 1912. Its activities have been heralded in his many published articles. He continued this directorate until May, 1919, when he was appointed director of the Massachusetts State Psychiatric Institute, founded for research in psychiatry in all its aspects. Great plans for elaborating work in this institute were on foot, many of which can now never be worked out.

As a chief he was most inspiring, always ready to answer a question (the more complex the better), to condone a misjudgment, or to give wise counsel. He instantly saw the fine qualities in a subordinate, found his interests and fused the two. His belief in their powers has proved a beacon in many lives.

In the laboratory he would often look painstakingly at the microscopical curiosities presented by some student, would suggest new modes of attack to prove the presence of supposed bodies, saying later, “It would have closed his interests forever if I had told him at once that they were artefacts.” In a five-minute conversation he could outline plans so far-reaching and convincing that without further persuasion one would want to work years on them, only regretting breathlessly that the days were not longer. He was always kind without losing perspective: one eager student made a diagnosis of infarct of the liver. He said, “Well, I have *seen* one, but they are very unusual.” A crushing remark might have been made.

He was really interested in the personal troubles of others. The serious illness of a classmate's relative would bring tears, the death of a friend would sadden him for days and he could find no comfort until he had thought of some way to express his appreciation of the friend's fine qualities in a fitting piece of work.

He had a rare endowment of humor—gentle, brilliant, spicy. It crept into his facial expressions and twinkled in his eyes. A favorite little joke was to call a friend on the telephone and

spell his name, S-o-u-t-h-a-r-d, ending with a chuckle or a pleased shout at the hearty welcome it received. "This world is divided into the *more or less*, and the all or *nothing* types of individuals," he would say after a difficult interview, and, "Certain people manage by heckling, others by jollying: Dr. ——— is an example of the former, and I of the latter." Happiness and optimism buoyed him over the rough places. Seeing the good in people and never forgetting to bestow praise where it was deserved, made for kindly intercourse. Friction was reduced in carrying out plans and policies while students and subordinates developed under his sympathetic direction a capacity for wider and better service.

Contention was always hard for him. A small quarrel weighed upon him. He would sit restlessly idle for half an hour if there had been an unkind word, finally rousing himself with, "Well cheer up."

It is a notable fact that he never lost his special interest in his two great masters, Josiah Royce (metaphysics and philosophy), and William James (psychology). Their influence, together with Gibbon's *Decline and Fall of the Roman Empire*, were admittedly his intellectual guides. The philosophic point of view so akin to his nature and so sedulously cultivated made him view as from a mountain top the relativity of a project, a personality or an event. With equal ease he understood human nature and its multifiform capacity for reactions. He was tolerant even of his bitterest opponents unless they were deliberately obstructive or vicious.

On new propositions his was always the *open mind*, seeing the worst first for the purpose of discarding it and retaining what was of permanent value. He has left to his students and associates a heritage of humor, brilliance, generosity and open mindedness and, best of all, hope.

M. M. CANAVAN.

AUGUST HOCH, M. D.

Through the death of August Hoch, psychiatry has lost an important representative. A wide circle of psychiatric workers and friends feel keenly the passing away of this much-beloved man. The loss is most keenly felt by the many who were closely acquainted with Hoch's work and what he might have given to us from the treasures of over 20 years of rare clinical observation and study.

A few years ago signs of a familial arteriosclerosis asserted themselves; a severe attack of sciatica in 1916 yielded but slowly. A change to a well-adapted existence in California seemed to have reestablished a safe balance; even a somewhat tedious infection of the foot during the last winter had cleared up; but shortly after a happy twenty-fifth anniversary of his wedding, the second day of a visit to San Francisco, where he had gone in part with the hope of working in the Medical Library, he was overtaken by a peculiar collapse, with profound renal insufficiency and a rapid development of uremia.

Hoch came to this country in 1887, when 19 years old, to take up the study of medicine at the University of Pennsylvania. He came from a happy family and a genial circle of friends at the gymnasium of Basel. His father, a minister, had for years been superintendent of the City and University Hospital of Basel, Switzerland. Hopes of an academic career must have been deeply implanted in him and may have determined him, together with his friend, Charles E. Simon, to follow Osler to the Johns Hopkins Hospital. He graduated from the University of Maryland in 1890. He worked largely with Henry M. Thomas, and translated Hirt's "Textbook of Nervous Diseases." His first paper dealt with hematomyelia. In 1893 he was chosen to become psychologist and pathologist in the extensive scheme of research laboratories planned by Dr. E. Cowles at the McLean Hospital, and he was sent abroad for further preparation. He went first to Strassburg, with Simon Flexner, to work on brain anatomy with Schwalbe, then to Leipsic, where he endeared himself to Külpe and Marbe

and Kiesow in Wundt's laboratory, and finally to Heidelberg, where he became one of the contributors to Kraepelin's drive into the domain of a medically useful experimental psychology. Hoch's study of the effects of tea and its oils was made the basis of some far-reaching generalizations by Kraepelin, especially concerning the facilitation of motor reactions. Hoch married Emmy Muench, of Basel, and then returned to start the 12 years of work at the McLean Hospital, first at Somerville and later in an excellent laboratory at the new hospital at Waverley, Mass. When I met him for the first time, September, 1895, he was living in the village with his wife and his only child, Susie, in a genial home, and was giving his whole enthusiasm and interest to a continuation of his psychologic and anatomic studies.

Edward Cowles had taken the superintendency of the McLean Hospital in 1879, after a brief training at the Hartford Retreat and a period of several years as superintendent of the Boston City Hospital. A man fond of speculation, with a decided yearning for progress, stimulated by Stanley Hall, at that time professor of psychology at Johns Hopkins University, he had an ambition to promote research in his well-endowed institution. His Shattuck lecture of 1885 foreshadowed his program of clinical speculation. He hoped to develop his psychiatric conceptions, leaving the clinical work very much on the old plan of having a few mainly administrative assistants, with the emphasis of innovation resting on the introduction of laboratory investigation. Dr. Hoch became the successor of Dr. Noyes, who had not been especially happy in this semi-academic and nevertheless isolated position. The chemical laboratory, destined to be the birthplace of Folin's reputation, soon was added; staff conferences aimed to harmonize the trends of work. The essentially different Worcester plan of organization laid the emphasis on putting the entire clinical staff on something like a research basis, the developing the laboratories in the service of this foundation as means in talents and funds became available, but always with a clear appreciation of the importance of a sound and critical setting. Kraepelin's revolution of psychiatry in 1896 and Nissl's joining the Heidelberg Clinic led to Hoch's second period of work with Kraepelin in 1897. He returned in spirit and fact the full-fledged psychiatric leader of the staff, as well as an especially well-trained histo-

pathologist, and one deeply interested in putting the ergograph work into the service of clinical problems. Dr. Cowles never made a complete readjustment to the natural result of these developments, so that the clinical publications were retarded; but Hoch's work became more and more the clinical research with a wise perspective regarding the laboratory investigations for which we all admire him. His interest in the ergograph studies did not cease; but a special report on a patient with alternating days of elation and depression may have served as a damper with regard to the pertinence of the reactions to the specific Kraepelinian disease-processes when the dominant process proved to be general paresis. In the first volume of the *Psychological Bulletin*, Hoch summed up the net result of that type of psychologic experimentation in its application to psychiatry.

The period of work with Nissl and Kraepelin in 1897 had a double effect on Hoch. He produced his studies on nerve-cell changes of the cortex in a case of acute delirium and a case of delirium tremens (1897) and on the nerve-cell changes in somatic diseases (1898), full of interesting details, in marked contrast to the numerous writings of that day which saw little more than "chromatolysis" in the cortex pathology. At the same time, from here on, the clinical studies began to predominate: the articles on mania and melancholia and manic-depressive insanity in the *Reference Handbook for Medical Sciences*, the unreality-feelings (1905), the studies on drug deliria (1906), the manageable causes of insanity (1909), the problem of toxic-infectious psychoses (1912), and a most important group of contributions to the study of personalities, the constitutional factors in the dementia præcox group, the mental mechanisms in dementia præcox, the relations of personality and psychosis, and the relation of insanity to the psychoneuroses. All these studies contain little gems of keen and yet direct and simple formulations of well-observed clinical cases, in wholesome contrast to Kraepelin's method of presentation, which overwhelms the reader with collections of fragments devoid of personal settings. It was this departure in the work of Hoch that made it possible and perhaps imperative for him to pay more and more attention to the rôle of the personality so strongly emphasized by American workers.

In 1905 Hoch was induced to take the position of first assistant physician of the Bloomingdale Hospital at White Plains, N. Y. He had done some teaching at Tufts Medical School, and he became professor of psychiatry at Cornell Medical College at the same time that he was called to the directorship of the Psychiatric Institute of the New York State Hospitals on Ward's Island, in 1909. As a teacher of the Cornell medical students and of the assistant physicians in the State Hospital system Hoch found opportunities for the fullest expression of his spirit of investigation and formulation. A period of study with Bleuler and Jung and von Monakow, in 1908, gave him an intimate familiarity with the structural and psychoanalytical problems, balanced by an unusually keen sense for intensive clinical study of his patients. It was with the greatest regret that his numerous pupils and colleagues saw him depart for California—a loss compensated only by the hope that in his new environment he would be able to bring out more rapidly monographs based on material from the McLean and the Bloomingdale hospitals and the Psychiatric Institutes.

From his advent at the Psychiatric Institute he took the greatest interest in the further development of the Bulletin of the New York State Hospitals into a psychiatric journal of the first order, the Psychiatric Bulletin. In California he hoped to found a special journal, but was finally induced to combine his effort with the newly planned Archives of Neurology and Psychiatry in order not to divide the efforts where union appeared most urgently needed. During the later years in New York he also proved a most helpful contributor to the interests of the social side of psychiatry, partly in connection with the National Committee for Mental Hygiene. The New York Psychiatric Society and the American Psychopathological Association count him among their most active and influential former presidents.

Hoch was not a generalizer. His strong point and first love was that of appreciation of the finer niceties of description and interpretation. He was not a philosopher, but a man with a keen sense for specific features and aspects of cases or problems. A definite cell alteration, a definite rhythm in the plotted results of his ergograph and kindred experiments, a fact such as passivity or specific traits revealed in the personality-study, which he

brought out in collaboration with his friend Amsden, reactions like distressed perplexity, or the death and rebirth concept in some of his patients, would absorb his whole-hearted attention, and would tend toward monographic studies. It is to be hoped that the rich material practically ready for publication will be added to the noteworthy array of publications from his pen.

Hoch's personality was somewhat retiring and at the same time most genial. He was capable of the keenest and heartiest enjoyment of friendship and social happiness with his chosen friends and his family. He gained the warmest affection of his patients. He always remained closely attached to his native country, but was a loyal and warm-hearted citizen of the United States, and deeply appreciative of the beauty of the east and south, and especially of California.

Hoch's work, his friendship and warm-heartedness will leave an enduring impression on all those who were fortunate enough to know him. His contribution to American psychiatry would fully deserve a memorial edition of his publications, together with the works which we hope his friends and co-workers will bring to speedy completion. What a pity that he should not have seen the day when his many friends and admirers might have celebrated with him the publication of his many-sided and well-poised collected works, somewhat as has recently been done to honor Cornelis Winkler on the occasion of the twenty-fifth anniversary of his professorship of neurology in the Universities of Amsterdam and Utrecht.

ADOLF MEYER.

HENRY MARTYN BANNISTER.

The departure from this life of Henry Martyn Bannister at Evanston, Illinois, on May 1, 1920, will have an especial though sad interest for the readers of this JOURNAL for he was a confrère who was held in high regard in our Association; had been an honorary member since 1890, and was known for his unusual ability and worthy services in the cause of psychiatry.

Henry Martyn Bannister was born July 25, 1844. He was the son of Rev. Henry Bannister, formerly of the theological faculty of the Northwestern University at Evanston, Illinois. Dr. Bannister was graduated from the National Medical College, Washington, D. C., in 1871, and during his career rendered varied and valuable services of a professional and scientific character. He was with the United States Geological Survey of the northwest territories in 1872, including Alaska, then distant and inaccessible, and endured there, in the cause of science, the rigorous hardships incident to an Arctic wilderness. On his return to Chicago, he was associated with Dr. James S. Jewell, an eminent neurologist of that day, and, with him, was a founder of the *Journal of Nervous and Mental Diseases*, the first important periodical in this country in the field of neurology, which later was transferred to New York and still exercises its valuable mission there. Dr. Bannister was largely responsible for the editorial work and the high appreciation won by this journal.

After the removal of the *Journal of Nervous and Mental Diseases* to New York, Dr. Bannister was associated for some years as assistant superintendent with the management of the State Hospital at Kankakee, rendering there professional services of a high order; also contributing to the literature of psychiatry various valuable papers. After retiring from the position at Kankakee, Dr. Bannister was for many years a member of the editorial staff of the *Journal of the American Medical Association*, in which position he did much valuable editorial work. He also wrote, in collaboration with the late Dr. Daniel R. Brower, a

text-book on insanity (*The Practical Manual of Insanity*: W. B. Saunders Company, 1902), the fruit of much skilled observation and experience. He also translated from the French a work which had the unusual distinction of being put in type and printed by patients in a hospital for the insane, the Utica State Hospital, *A Practical Manual of Mental Medicine*, by E. Regis.

Dr. Bannister had suffered for many years prior to his death from arthritis deformans, but still continued to accomplish much literary work, especially in the field of medicine. He was a man of very extensive reading, unusual intellectual ability and force: a man of high character and sterling worth, winning universal kindly regard. He was eminent not only in medicine, but in the fields of literature and science. He possessed stores of knowledge, making him always an interesting companion, and his loss will be deeply regretted by a wide circle of friends and associates.

In a work where most men are apt to claim more than their due, Henry M. Bannister, a modest, retiring and over-scrupulous man, honest to the last degree, never realized the honor and recognition he really merited. Many of the most discerning in the scientific world were acquainted with his attainments, but a more aggressive man, even though far less meritorious, would have been more generally recognized.

RICHARD DEWEY.

WILLIAM P. CRUMBACKER, M. D.

Dr. William Pollock Crumbacker came of an honored family of physicians, widely and favorably known, in an early day, in Eastern Ohio, Western Pennsylvania, and West Virginia, both his father and grandfather being honored members of our profession.

Dr. Crumbacker himself was born at Wheeling, West Virginia, December 20, 1857. After a very extensive academic education, at Philadelphia and elsewhere, he took up the study of medicine, and graduated from the Medical College of Ohio (now the Medical Department of the University of Cincinnati) in 1882, and some time later pursued post graduate work in the New York Polyclinic.

In 1897 he visited the hospitals in Dublin, Ireland, and Edinburgh, Scotland, making special investigation concerning the treatment of nervous and mental disorders, in Great Britain. In fact, he has been a faithful and tireless student, especially in the fields of his chosen work, up to the end.

In the earlier years of his professional life, after having practised medicine with his father for several years, he entered the State Hospital at Athens, Ohio, as an assistant physician; and later on was called to the superintendency of the Athens State Hospital, where he remained in service some five years, and was called to fill a position as superintendent of the West Virginia State Hospital, at Weston. He left there, to engage in private practice, in Athens, Ohio, and later on, in Pasadena, California, from whence he was called to take charge of the superintendency of the Iowa State Hospital, at Independence, where he began his duties, July 1, 1902. His service in this state at Independence has been continuous, and most satisfactory, and beneficent, gaining for him the warm regard and esteem of his professional brethren, also the lasting gratitude of patients and friends alike.

He introduced many improvements in the service, and the influence of the good work done must ever remain a lasting monument to his memory.

His last summons came to him Friday morning, May 14, 1920. He had been sick some three weeks previously, being stricken while in active service of the state and its afflicted people.

Dr. Crumbacker was united in marriage to Miss Emma L. Bower, of Athens, Ohio, who has been a true wife and companion to him. To them was born one son, James Bower, now a student in Harvard University. Their family life was a happy one, and like everything else connected with Dr. Crumbacker, expressive of the loftiest ideals.

He was for many years an honored and esteemed member of the American Medico-Psychological Association. Many of its members, with the writer, will ever remember him as a faithful, loyal friend, a wise counselor, and a representative of all that is noblest and best in our profession.

It is said that in years Dr. Crumbacker was not an old man, and he might have lived many years of usefulness; but life is not measured by a span of time, by the circling orbs; it is valued by the feelings felt, the thoughts thought, and the deeds done; and measured by this standard, Dr. Crumbacker, our friend, was a very, very old man. And his work is not undone. As the days pass, and the years go on, his influence remains, grows, and expands, to the aid of our needy brethren, to whom his life was given. In our material world, we know that the grain of sand, disturbed by the careless foot, has its effect on the farthest blazing sun, in the uttermost depths of the universe. How much more is that true of an exalted human soul? Who can put limits to the influence of a noble personality?

Those who knew him esteemed him, and will esteem him ever, for his excelling traits of character, for his charity—a clarified charity towards the weakness and frailty of our fellow-travelers here on earth.

He was ever tolerant and kind. He embodied the spirit of our profession, yours and mine, and for him might well have been said the prayer of Drumsheugh.

You and I, who knew him, will miss him, in the days to come; but we are not as those who sit in darkness and are without hope. A few days, and we also shall be summoned to pass through the portals, and beyond the veil, and then we hope again to meet our friend.

MAX E. WITTE.

EDWIN EVERETT SMITH, M. D.

Dr. Edwin Everett Smith was born in Hanover, New Hampshire, August 28, 1844, and died in Cold Spring on the Hudson, May 24, 1919, in his seventy-fifth year. Death occurred after an illness of only a few days. Dr. Smith had been living in Cold Spring for five years, having retired from the practice of medicine. Although retired, the need for his services became great during the influenza epidemic in the fall of 1918, so he again took up practice for several months; but he himself contracted influenza when the epidemic was on the wane, and did not again resume practice. He is survived by his wife and four children. Mrs. Smith was the oldest daughter of the late Scott Lord of New York City. Of the four children, two have followed their father's profession.

Dr. Smith received his early education in New Hampshire and graduated from Dartmouth College in 1868. He continued his college associations throughout his life, and attended his fiftieth anniversary class dinner in 1918. He was a member of the Alpha Delta Phi fraternity and of the Phi Beta Kappa Society of Dartmouth College.

Dr. Smith received his preliminary medical education at University of Ann Arbor, Michigan, and graduated from Long Island Medical College. For a short time he was interested in surgery, but later took up psychiatry, which specialty he chose for his medical career. He was engaged in this branch of medicine at first as resident physician, City Hospital, Blackwell's Island, during the period that mental cases were admitted there; later he was resident physician at the State Hospital at Utica, N. Y., where he was one of the assistants of Dr. Gray, from whom so many of the senior men of psychiatry received their early instruction and inspiration—Dr. Edward N. Brush, Dr. Charles W. Pilgrim and Dr. G. Alder Blumer, to mention but three. Subsequently Dr. Smith was appointed assistant physician at the State Hospital for the Insane at Morristown, New Jersey, and later became medical superintendent of that institution for a period of two years. As was the case with many institutions at that time the

need of undivided authority, executive as well as medical, for the directing physician, was not fully appreciated by the managers of the hospital, and Dr. Smith found himself hampered in carrying out such reforms as he contemplated. On resigning this position in 1886 he opened a private sanitarium in Connecticut. This sanitarium burned in 1912, fortunately without loss of life.

During his superintendency at Morris Plains Dr. Smith had as assistants Dr. William L. Russell, at present superintendent of Bloomingdale Hospital, White Plains, New York, and the late Dr. William Mabon, who at the time of his death, was superintendent of Manhattan State Hospital, Wards Island, New York.

One with psychiatric interests is likely to have a broad knowledge of human nature, and may succeed in being both a spectator in life and an active participator. This may be said of Dr. Smith, for, while a man of unusual strength and energy, he nevertheless took keen interest in the contemplative side of life. He was a wide reader, made a hobby of plants and gardening, and keenly enjoyed the life of the country. A man of unusual stature and physique, being six feet three inches in height, and of venerable appearance, with a kindly smile for every one, he is recalled as he appeared after he retired from active practice, having reached three score years and ten, surrounded by the children of the village who knew him so well and to whom he appeared somewhat as the benevolent and legendary figure of St. Nicholas.

Life offers a heaped-up measure of happiness to one so constituted, who, while enjoying it fully as it passes, has at the same time the ability to impart that enjoyment to others. Dr. Smith, without being aware of it, by his own cheerfulness and optimism and confidence imparted these feelings to the minds of those about him. His sincerity and genuineness made for lasting friendships, to which friends of many years' standing can testify.

SANGER BROWN, II.

LEONARD CHAS. MEAD, M. D.

Leonard Charles Mead, M. D., LL. D. was born on the family homestead in Hampden Township, Columbia County, Wisconsin, January 18, 1856, the son of Ezra and Sylvia (Barber) Mead.

Dr. Mead spent his early years on his father's farm, after the manner of most farmer boys of that time, helping in the fields in summer and attending the district school in the wintertime. He was enabled to complete the high school course at Columbus, and then entered the State University at Madison, where he attended during 1874-6, intending to take up mechanical engineering as a profession. He defrayed his expenses by teaching school, at first in country schools, but later becoming principal of the schools at Rio, Wisconsin. In the fall of 1878 he entered Rush Medical College of Chicago, from which he graduated in the spring of 1881.

After graduation Dr. Mead established himself in practice at Good Thunder, Minn., but a year later removed to Elk Point, South Dakota, where he practiced for eight years. On May 5, 1890, he was appointed assistant superintendent to the South Dakota Hospital for the Insane at Yankton, South Dakota, and one year later was promoted to the superintendency. Up to this date, May, 1891, the hospital had been a political football, kicked about to reward political services, and for a long time had averaged one superintendent per year, the work inaugurated by one being sure to be undone by his successor. It was Dr. Mead's first business to organize the institution upon a business and professional basis and lift it from the degrading domain of party politics. He possessed superb executive ability and the happy faculty of directing the movement of the large number of employees and officers without friction.

Dr. Mead was equally successful as a business man as he was as a physician and executive, and was especially fertile in mechanical engineering. During his administration he planned and directed the construction of the institution as it is to-day with the exception of the old main building. He was a pioneer in concrete construc-

tion, having planned and erected one of the first reinforced concrete buildings west of Chicago. He recognized and emphasized the value of occupation not only as a therapeutic measure but as a means of developing chronic custodial cases into useful members of the hospital community.

He took a keen and active interest in the establishment and planning of the Watertown State Hospital, work on which was begun late last fall.

Dr. Mead was a man of force; his friends were legion. He possessed a most engaging personality, was a brilliant conversationalist, and his influence was impressed on all who came in contact with him. In his death the state has lost one of its most able citizens, the insane one of its most earnest champions and his associates one of their truest friends. I count myself fortunate in having been associated with him both as friend and colleague for nearly 20 years.

He was married in June, 1886, to Miss Matilda Frazer Gardener, of Sparta, Wisconsin, who survives him and who was his constant inspiration during his long and faithful professional and public service.

As a fitting recognition of distinguished work and services to the state, the University of South Dakota conferred upon him the degree of Doctor of Laws in May, 1918. Dr. Mead was for many years a trustee of Yankton College, and a Mason of the 33d degree. He was also an active member of the Yankton District Medical Society; the South Dakota Medical Association (president, 1907); fellow of the American Medical Association, and Sioux Valley Medical Society.

The last two years of his life proved his patience and forbearance during his long illness. For more than a year he had been confined to his apartments the greater part of the time, and during the last three months was confined to his bed.

His interest in the institution was especially keen during his last illness, and he continued to direct the policies of the institution which he served so long and well until the last day of his life. The end came January 13, 1920, at 9.30 P. M. He was laid at rest January 17, 1920, on the hospital grounds according to his expressed wish.

G. S. ADAMS.

DR. JAMES THOMAS SEARCY.

Dr. Searcy was a native of Alabama, having been born in Tuscaloosa, on December 10, 1839. He was the son of Dr. Ruben Searcy and Mrs. Abbie Fitch Searcy. He grew up and was educated in the schools of Tuscaloosa, and in the University of Alabama, graduating in the class of 1859. He was a member of the Phi Beta Kappa Fraternity. He served throughout the Civil War in the artillery branch of the service of the Confederate Army. After the Civil War he took up the study of medicine, finishing with the class of 1867, University of New York. After graduating in medicine he lived in Tuscaloosa, pursuing his profession in the general practice of medicine, winning much success and honor and filling the highest offices of his local medical society, and the State Medical Association before reaching middle life. He was always regarded as a leading physician of the state.

On January 22, 1867, he was married to Miss Ann Rebecca Ross. His home was blessed, as a result of the marriage, with 12 children—eight sons and four daughters.

His father, Dr. Ruben Searcy, was a member of the Board of Trustees from the time the Alabama Insane Hospitals were established. After his father's death, Dr. James T. Searcy was a member of the board until the death of Dr. Peter Bryce, superintendent, in 1892. When Dr. Bryce laid down the cares and burdens of life Dr. Searcy was called to the position of superintendent, serving from 1892 until he retired July 1, 1919. His reputation and ability as a specialist in psychiatry and a man of high intellect and good judgment was long recognized.

In 1915 he served as president of the American Medico-Psychological Association. His long and successful career, being active in mind and body until within one year of his death, was beyond what the average man can hope to attain. He always had a profound interest in this organization, attending regularly, taking an active interest in its advancement and in the questions of psychiatry and hospital management. In his death this association has lost one of its most loyal, faithful and valuable members. All who knew him loved him, and his writings on subjects pertaining to his specialty will remain as contributions of value to its literature.

W. D. PARTLOW.

JOHN CHRISTOPHER MITCHELL, M. D.

Dr. John C. Mitchell, medical superintendent of the Ontario Hospital, Brockville, Canada, died at his post on May 2, 1920.

Born in Lindsay, Ontario, on July 25, 1850, he taught school in his native town from 1868 till 1871, and then entering the Trinity Medical School, Toronto, graduated from Trinity University in 1875.

He entered general practice in Newtonville, and after three years moved to the village of Enniskillen, Durham County, where he enjoyed a most busy and lucrative practice for 24 years. During this time he also took an active interest in the political affairs of this country, and was in 1898 a candidate for parliamentary honors in the Liberal interests.

In 1902, finding a large general practice too taxing, he decided to devote himself to special work and entered the government service as an assistant-physician in the Hospital for Insane, Toronto, and incidentally was lecturer in pyschiatry in his alma mater and Toronto University until the latter part of 1904, when he took charge of the newly opened Hospital for Epileptics at Woodstock; after one year there he was transferred to the Hospital for Insane at Brockville as assistant superintendent; he subsequently moved to the same position in Hamilton on November 1, 1910, remaining there until May 15, 1911, when he returned to Brockville to assume the superintendency, which he most efficiently filled until the time of his decease.

Both in private practice and institutional life his geniality and outstanding ability were markedly recognized and as an alienist, he was acknowledged to be one of the foremost in Canada.

He was largely instrumental in the formation of the Medical Society of the United Counties of Leeds and Grenville—a past president of the Ontario Medical Association, and member of the American Medico-Psychological Association.

His energies were not entirely devoted to his profession as he was an active Mason and member of the Preceptory and Templars and also an enthusiastic devotee of all sports, notably, boating, curling and lawn bowling.

In his "Crossing the Bar" we all feel that we have lost awhile a true friend, and thoughtful, conscientious confrère.

W. M. ENGLISH.

DR. HENRY L. ORTH.

Dr. Henry L. Orth died at his home in Harrisburg, Pa., on May 18, 1920, after an illness of two weeks' duration, an illness which was the culmination of a period of semi-invalidism which led to his retirement from active hospital work.

Dr. Orth came of a family which first settled in Pennsylvania in the year 1730 and which was distinguished for the political, professional and industrial achievements of its various members. He was born in Harrisburg on August 17, 1842, and was the son of Dr. Edward L. Orth who practiced medicine in that city from 1834 to 1861. His preliminary education was secured in the Harrisburg Academy and on its completion he entered Yale University in 1859, remaining until 1861. At the outset of the Civil War he was appointed Medical Cadet in the United States Army and received his commission to the same position in the Regular Army in 1863. In this capacity he served until 1865 after which time he attended the Medical Department of the University of Pennsylvania, from which he was graduated in 1866, and soon afterward began the practice of medicine in his native city. On June 30, 1868, he was married to Miss Elizabeth Bridgeman Dixon, of Harrisburg, who, with one son, Edward L. Orth, of Cohoes, N. Y., and two daughters, Miss Anna S. D. Orth and Miss Roberta E. Orth, of Harrisburg, survives him, as does a brother J. Wilson Orth, of Pittsburgh.

For many years Dr. Orth held an enviable position among the surgeons of the State during which time he served as surgeon to the Northern Central R. R. Co. and to the Pennsylvania R. R. Co., also as visiting surgeon to the Harrisburg Hospital, and as president of the Pennsylvania Board of United States Pension Surgeons.

He was honored by his fellow physicians in being selected as delegate from Pennsylvania to the International Medical Congress of 1876 and also that of 1887, and as President of the Pennsylvania State Medical Association in 1893.

Dr. Orth was an early member of the Dauphin County Medical Society, a charter member of the Harrisburg Academy of Medi-

cine, a member of the Pennsylvania State Medical Association, of the American Medical Association, and of the American Medico-Psychological Association. He took also a prominent part in the social life of Harrisburg, being a charter member of the Harrisburg Country Club, one of the organizers of the Englenook Club, serving also on the first Board of Governors of the Harrisburg Club. In 1889 he was appointed as a Trustee of the Pennsylvania State Lunatic Hospital, and on August 18, 1891, was elected superintendent of that Institution. This work which appealed to his altruistic nature, was destined to be the great work of his life, and surrendering a large and lucrative practice he accepted the position tendered him. Entering upon the duties of superintendent, he formed the ambitious project of replacing the old institution by a hospital which should be modern in every respect, and conducted upon the most advanced scientific principles. With this end in view he undertook the work of remodeling the grounds, razing the old structure and erecting an entirely new hospital on the cottage plan. He had the rare gratification of seeing all his designs completed before he relinquished the reins of administration, which by failing health he was compelled to do in the latter part of the year 1917.

Dr. Orth was a man of vision, of energy and determination, a strict disciplinarian, and one who was unsparing of self when action was demanded. Throughout his whole service of 27 years as superintendent of the hospital he held the respect of every one who had dealings with him. His quiet humor and his kindness of heart, which those who knew him best appreciated at their true worth, were not revealed to chance acquaintances. With intellect undimmed, with courage unabated, surrounded by his devoted family and friends, he passed calmly the last few months of a life rich in usefulness and in honorable achievement.

E. M. GREEN.

DR. BRITTON DUROC EVANS.

Dr. Britton Duroc Evans was born in Caroline County, Maryland, October 1, 1858, son of Dr. Louis N. and Lucinda Boone Evans. His father was a physician and was engaged in general practice in the state of Maryland for many years. Dr. Evans received an academic education and, showing a leaning to the ministry, was licensed as a local preacher in the Methodist Episcopal church, but later (1882) he began the study of medicine and was graduated from the College of Physicians and Surgeons of Baltimore, Md., in 1885. After practising for about two years in Millington, Md., he was offered the position of assistant superintendent of the Maryland Hospital for the Insane at Catonsville, where he served for nearly five years under the superintendency of Dr. Richard Gundry to whom he became greatly attached and whose precept and example he always respected and revered. He accepted the superintendency of the Institution for Feeble-minded at Owens Mills, Md., early in 1892 and resigned to accept the position of medical director of the New Jersey State Hospital at Morris Plains in June, 1892. New Jersey at that time was struggling with an innovation in state hospital management, the so-called "dual system," consisting of a medical department and a business department entirely independent of each other, each being responsible directly to a board of managers vested with all the powers of a lunacy commission, which, however, met but once a month at the institution. Seven tempestuous years of a system so calculated to cause and to increase friction in management had brought the work of the institution at Morris Plains to a very low ebb. Dr. Evans displayed unusual executive ability in riding the shoals of this anomalous and difficult, not to say vicious, administrative system and finally triumphed over it by being appointed superintendent and chief executive officer.

During the 27 years of Dr. Evans' connection with the State Hospital at Morris Plains as an administrative head he saw the population under his care increase from about 900 to 2700, and his anxiety for the safety and welfare of the state's insane popu-

lation increased accordingly. The increased accommodations came along so slowly that there was scarcely ever a time when the institution was not overcrowded, and this became alarmingly true during the last three or four years of Dr. Evans' life. During this period he embraced every opportunity to try to arouse the state to a sense of its responsibility in providing adequate facilities for the care of the insane; could he have lived a couple of months longer he would have seen the beginnings of a comprehensive program which he would have recognized as his heart's desire.

Dr. Evans was a man of unusual force and ability, and during his long and successful career at Morris Plains he made a wide circle of friends and acquaintances. His geniality and nimble wit were always in evidence and his kindliness of heart is permanently wrought into the great monument to which his 27 years of untiring effort have contributed so much of permanent character.

He was married in 1889 to Miss Addie E. Dill, of Wilmington, Del., who with four children survives him.

THOMAS B. PROUT.

JAMES MONROE BUCKLEY, D. D.

Seldom is this society called upon to pay honor to the memory of a member who was not of the medical profession, and seldom is it called upon to pay honor to any physician who has done more to promote the hospital care of the physically and mentally sick than did James Monroe Buckley, Doctor of Divinity, who died on February 8, 1920, at his home in Morristown, New Jersey. Dr. Buckley was born at Rahway, New Jersey, on December 16, 1836, received his early education at Pennington Seminary, and entered Wesleyan University at Middletown, Connecticut, but in his second year there his health failed. He came from a family which, on his father's side, showed a grave tendency to tuberculosis, and at the age of 21 Dr. Buckley exhibited symptoms of pulmonary affection, followed a year later by hemorrhages. Through a course of systematic exercises in the open air, careful attention to hygiene, and practice in deep-breathing, coupled with an invincible determination not to die, Dr. Buckley for 10 years fought the battle for life and health, and at the end of that time won a complete victory.

This experience undoubtedly intensified his natural interest in medical matters. His early work as pastor in the Methodist Episcopal church brought him into contact with the need for hospitals, and soon after he became editor of the *Christian Advocate* in 1880 he took up active efforts along this line, with the result that by 1881 he had been instrumental in raising sufficient funds so that the Board of Managers of the Methodist Episcopal Hospital in Brooklyn was selected and organized, with Dr. Buckley as its first president. He held this office continuously until his resignation in 1917, when he was made President Emeritus, and attendance at the meetings of this board was one of the last duties which he relinquished. From very early days, Dr. Buckley felt a deep interest in the subject of abnormal mentality, and his leisure time was devoted in large measure to the study of congenital and later-appearing mental disorders, with special attention to delusions, hal-

lucinations, trances, panics and occult phenomena. In 1892 he published a volume on Faith Healing, Christian Science, and Kindred Phenomena, in which he gave a thoroughly rationalistic study of the subject. From time to time he produced pamphlets and articles dealing with mental diseases, and in all his travels both in this country and abroad he made it a point to visit hospitals for mental cases as well as those for strictly physical ailments. In 1892 he was elected to the board of managers of the New Jersey State Hospital at Morris Plains; in 1896 he became vice-president of the board, and in 1912, president, which office he held until his retirement in 1914. He served also for five years on the board of managers of the New Jersey State Hospital at Trenton. He was largely instrumental in the erection of a separate institution for the epileptic in New Jersey, and was president of the board of managers of the State Village for Epileptics at Skillman from its foundation until he resigned in 1903.

Dr. Buckley received the honorary degrees of A. M. and D. D. from Wesleyan University, LL. D. from Emory and Henry College, Virginia, and L. H. D. from Syracuse University; he was a member of numerous organizations, boards, and committees; he was three times a delegate to the world Ecumenical Conferences of Methodism; he was called the "bishop-maker" from his influence in the general conference; but an honor which he himself regarded as one of the highest which he ever received, and in which he took much satisfaction, was his election as honorary member of the Medico-Psychological Association of America. Eighty-three years is a long span of life for a man, reckoned in time, but reckoned in achievement Dr. Buckley's life appears far longer. Many men perform great work in one selected line, but Dr. Buckley was a successful pastor; he was a productive writer; he was a remarkable editor; he was the dominating influence in the Methodist Episcopal church for a generation, urged over and over again to become a bishop, but always declining; he was trustee of Drew Seminary, Goucher College, and Wesleyan University, and was for years president of the Methodist Board of Foreign Missions; as founder and administrator of hospitals and kindred institutions, he leaves a record of which any physician might be proud. Instead of one life work, he had a half dozen, and in each field he accomplished progressive, concrete, productive results.

Necessarily, to bring about such achievements, Dr. Buckley was a man of brilliant mind and untiring energy ; keen, forceful, logical, with a phenomenal memory and perfect mastery of the two-edged sword of wit and sarcasm, he was at his best in debates and controversies. But there was another side to his personality, the side which won and held his friends, the side which made him loved, as well as admired and feared. Dr. Buckley possessed to an unusual degree the gift of charm and magnetism ; he was a delightful man to meet, an amusing and entertaining companion, bubbling with an inexhaustible spring of humorous anecdote. His sincere personal interest in people, whatever their grade or condition, always rang true. He was as unswervingly loyal to his friends as to his convictions, and as staunch in their defence. Those burdened and in need always touched his sympathies. Up to the time of his death he continued to pay frequent visits to certain old patients on the wards at Morris Plains, and their welfare was a matter for his personal interest to the very last. Dr. Buckley's life is done, but the policies which he shaped and the institutions which he founded are still living and growing along the lines which he marked out, and his influence will extend in widening circles far into the future, for he belongs to those men the work of whose hands is established and shall not perish.

MARCUS A. CURRY.

AMOS J. GIVENS, M. D.

On July 7, 1919, Dr. Amos J. Givens died at his home in Stamford, Conn.

He was born in Cortland, N. Y., about 57 years ago, and soon after having been graduated from a medical college, entered upon what was to be his life work.

He was a member of the staff of the Minnesota State Hospital for the Insane, and held a similar position in the Massachusetts State Hospital in Westboro, and was an interne under Dr. Talcott in the Middletown State Hospital (N. Y.). For several years he was resident physician at a private sanitarium, the Glen Mary Home, at Oswego, N. Y., and from there came to Stamford at which place he resided until his death.

In 1891 he founded Stamford Hall for the treatment of nervous and mental diseases, in the treatment of which he was eminently successful. The institution thrived and is now one of the largest in the country.

Dr. Givens was not only successful as a physician, but was an exceedingly able business man, and was connected with many of Stamford's industries. At the time of his death he was vice-president of the Fidelity Title & Trust Company, was a large owner of real estate, and was interested in the development of the city of Stamford. About 1913 Wesleyan University conferred upon him the degree of Doctor of Law, and he served for some years as one of the directors of that institution. Among the societies to which he belonged may be mentioned, the American Medical Association, the American Medico-Psychological Association, the New York Society of Medical Jurisprudence, the Stamford Academy of Medicine, and the Medical Society of the State of Connecticut.

In his will, Dr. Givens has made ample provision for the institution that he successfully founded, so that its work will not in any way be interfered with by financial considerations. He is survived by his wife and three children, Webster, Cecil and Marie. His home life was very happy, and it was in his home that he found the relaxation that was welcome to a man whose life was so full of serious work.

FRANK W. ROBERTSON.

LIVINGSTON S. HINCKLEY, M. D.

Dr. Livingston S. Hinckley died of pneumonia, complicated with endocarditis, on February 22, 1920, at St. Barnabas Hospital, Newark, N. J. Age 65 years.

Dr. Hinckley was born in Albany, N. Y., August 28, 1855, the son of Dr. John Warren Hinckley who was prominent in his profession, and brother of Isabella Hinckley the famous singer. He was educated in the schools of New York City, studied medicine under Dr. John L. Perry of New York and was graduated from Bellevue Hospital Medical College in 1878. He received an appointment to the New York City Lunatic Asylum where for 18 months he served as first assistant physician and finally as assistant superintendent. At the end of three years service he resigned to take up private practice. After a year in New York City he removed to Avon Springs, N. Y., where he established a private sanitarium. In November, 1884, he received the appointment as first Medical Superintendent of the Essex County Asylum, Newark, N. J., in which capacity he served for 17 years.

Much progress was made in the general treatment of patients, and the institution became recognized as a model county asylum. Among the features introduced by Dr. Hinckley were a training school for nurses for both sexes, established in 1886, a day school for patients, a monthly paper, the "Home Teacher," edited by the patients, and an abundance of various amusements and occupations for the inmates.

In 1901 Dr. Hinckley entered upon general practice in Newark. He frequently acted as an expert for the state in criminal cases involving questions of sanity and gained prominence as an alienist.

He was a member of the Medico-Psychological Association, the American Medical Association, the Essex County Medical Society, and a permanent delegate to the New Jersey State Medical Society. He was a veteran of the 22d Regiment N. G. S. N. Y., a member of St. Johns Lodge F. and A. M. and vice-president of the West End Club of Newark, N. J.

Surviving him are his wife and a son, Dr. Livingston S. Hinckley, of Newark, N. J.

GUY PAYNE.

DWIGHT S. SPELLMAN, M. D.

Dr. Dwight S. Spellman, senior assistant physician, Manhattan State Hospital, was accidentally drowned in the Tom's River, New Jersey, December 18, 1919. He was spending the day at his bungalow on the Jersey coast, and while walking across the frozen river to procure a Christmas tree for his family, broke through the ice and was submerged in the freezing water. A boy of thirteen who accompanied the doctor also broke through, but fortunately was able to reach solid ice and extricate himself. His cries brought help, but it came too late to rescue Dr. Spellman.

Dr. Spellman was born at Rootstown, Ohio, in 1867. He attended the public school of his native village and the high school at Minerva. His medical education was obtained in the College of Physicians and Surgeons at Baltimore, Md., from which he received his degree of Doctor of Medicine in 1889. He accepted a position as assistant physician in the New York City Asylum in 1890, and the remainder of his life was devoted to the care of the insane in the same institution, which in 1896 became the Manhattan State Hospital. His work for years was among the more acute forms of psychoses, and he was considered a psychiatrist of sound judgment and keen acumen. He kept in close touch with the latest developments in psychiatric science and although he published but few of his observations, and consequently was not widely known, his ability was recognized by his colleagues and his service in the Manhattan State Hospital was greatly appreciated.

He was a member of the American Legion of Military Surgeons, the American Medico-Psychological Association, the Masonic Order and several local medical societies. He was commissioned as captain during the war and was stationed for several months at Plattsburg, N. Y.

Dr. Spellman's sudden death came as a shock to his many friends in the state hospitals, as well as to his wide circle of acquaintances in other walks of life.

The funeral services in the Main Building on Ward's Island were conducted by Rev. Dr. White of the Episcopal Church and by the Masonic Order. The body was taken to Ohio for interment.

Dr. Spellman is survived by a widow and two children.

JOHN T. W. ROWE.

DR. MARCEL J. DE MAHY.

Dr. Marcel J. de Mahy, son of Dr. Henry J. de Mahy and Cecilia M. (Moses) de Mahy, was born in New Orleans, La., on May 16, 1886. He was graduated from St. Aloysius College, that city, in 1902. Dr. de Mahy had at first decided to enter commercial life, and for several years was connected with the firm of Ralli Bros., cotton factors. He soon realized, however, that such was not his calling, the blood of physicians, for generations back, coursing through his veins urged him on, and he matriculated at Tulane College of Medicine, in his native city. He received his diploma therefrom, in May, 1910. In July of the same year he passed the necessary examinations with brilliant success, and was admitted at the Touro Infirmary where he remained for two years.

Dr. de Mahy after leaving the Touro Infirmary, followed the general practice of medicine for a couple of years, he then determined to specialize in neurology, and to better fit himself for this branch, visited hospitals and sanitariums of the east and north noted for the treatment of such diseases. He was on the staff of the Touro Infirmary, and one of its youngest members. He devoted some of his time to their out-door clinic. Though still young in years he had already achieved success, and had made his mark. He and those who loved him, had every right to believe that his future was assured, when the scourge of 1918, the terrible Spanish Influenza which spared neither the good nor the useful, claimed him as one of its victims, and he succumbed to it, on October 15 of that year. Ten days later he was followed to the grave by his young wife, Carmen Fleming, whom he had married in July, 1912. Dr. and Mrs. de Mahy are survived by a young son, Bernard Moses de Mahy, a little over two years old, his parents and one sister, Mrs. H. Gelpi.

WALTER J. OTIS.

PAUL L. CORT, M. D.

Paul Lange Cort, son of Rev. Cyrus Cort, D. D., and late Susan Cort of Baltimore, Maryland, was born at Hewig City, Illinois, November 20, 1870.

Dr. Cort was a graduate of Jefferson Medical College, Philadelphia and was a registered physician in New Jersey and Pennsylvania. He was elected first resident physician at Mercer Hospital on November 4, 1895, and served a full term, and later became a chief of staff. On June 15, 1897, he was elected assistant physician at the New Jersey State Hospital, Trenton, from which position he resigned November 15, 1904, to take up private practice in Trenton, a specialist in nervous and mental diseases. On November 16, 1905, Dr. Cort married Mary R. Scudder, daughter of the late John H. Scudder and Martha Scudder.

He was a member of Loyal Lodge of Masons Crescent Temple, Ancient Arabic Order Nobles of the Mystic Shrine, the Trenton Club, the American Medico-Psychological Association, Philadelphia Psychiatric Society, American Medical Association, Medical Society of New Jersey and the Mercer County, New Jersey, Medical Society. He was also a surgeon in the New Jersey Society Sons of the Revolution, medical examiner for several life insurance companies, consulting neurologist to the New Jersey State Hospital, visiting physician to the Widow's Home and member of the advisory Board of Union Industrial Home. He was a member of the First Presbyterian Church, Trenton, New Jersey.

Dr. Cort died at his home 144 W. State St., Trenton, New Jersey, June 12, 1919. "He was a man of forceful but genial and delightful personality, hiding his suffering behind a cheerful countenance and meeting death, which he knew to be imminent, with great fortitude. His loss is one which will ever be felt by a host of friends."

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